AMENDED IN SENATE JULY 7, 1996

AMENDED IN ASSEMBLY MAY 23, 1996

CALIFORNIA LEGISLATURE—1995–96 REGULAR SESSION

ASSEMBLY BILL No. 3483

Introduced by ~~Committee on Budget (Miller (Chairman), Alby, Baugh, Cunneen, Harvey, Hawkins, Kaloogian, Knowles, Kuykendall, Morrow, Olberg, and Richter)~~ *Assembly Member Friedman*

(Coauthor: Senator Solis)

April 10, 1996

An act ~~relating to public social services, and declaring the urgency thereof, to take effect immediately.~~ *to amend Sections 1797.254, 102247, 102250, 116590, 116600, 120955, and 123227 of, to amend and renumber Section 4019.10 of, to add Sections 116377 and 123228 to, to add Chapter 12 (commencing with Section 1799.202) to Division 2.5 of, to add and repeal Section 103640 of, the Health and Safety Code, to amend Sections 4359, 4643, 5778, 14005.21, 14005.8, 14005.85, 14021.6, 14105.31, 14105.33, 14105.35, 14105.37, 14105.38, 14105.39, 14105.4, 14105.405, 14105.41, 14105.42, 14105.91, 14105.915, 14105.916, 14132.44, 14132.47, 14132.90, 14133.22, 14148.5, and 14163 of, to amend and repeal Section 4791 of, to add Sections 4681.3, 4776.5, 6600.05, 7200.05, 14005.81, 14511, and 14512 to, to add and repeal Chapter 14 (commencing with Section 18993) of Part 6 of Division 9 of, to add and repeal Division 24 (commencing with Section 24000) of, and to add and repeal Sections 14087.305 and 14105.335 of, the Welfare and Institutions Code, and to amend Section 24 of Chapter 305*

of the Statutes of 1995, relating to health, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 3483, as amended, ~~Assembly Committee on Budget~~ *Speier.* ~~Medi-Cal~~ *Health.*

Existing law creates an Emergency Medical Services Authority in the Health and Welfare Agency. It requires the authority to, among other things, provide technical assistance to agencies, counties, and cities for developing components of emergency medical services systems.

This bill would establish the Emergency Medical Services for Children Program within the authority, contingent upon available funding, and would authorize local emergency medical service agencies to develop the program and, if so, to integrate an emergency medical services for children program component, as specified, into their emergency medical services plan. It would provide that no more than $120,000 per fiscal year shall be expended from the General Fund by the authority for the program. This bill would require the authority, among other things, on or before March 1, 2000, to produce a report for the Legislature describing any progress made on the implementation of the program.

Existing law, the California Safe Drinking Water Act, requires the State Department of Health Services to administer provisions relating to the regulation of drinking water and public water systems.

Existing law requires the department to assess fees to public water systems for specified costs and requires that the department submit an invoice to the water systems prior to September 1 of the fiscal year that the costs are incurred.

This bill would limit the application of this requirement to public water systems serving 1,000 or more service connections or treating water on behalf of one or more public water systems and would revise the invoice submission procedures.

Existing law continuously appropriates funds in the Safe Drinking Water Account for purposes of the California Safe Drinking Water Act.

This bill would delete the continuous appropriation and would provide for use of these funds for purposes of that act upon appropriation by the Legislature.

Existing law repeals these and related fiscal provisions on January 1, 1997.

This bill would, instead, repeal those provisions on January 1, 2002, and would extend total fee limitations indefinitely.

Existing law establishes the State Vital Record Improvement Account in the Health Statistics Special Fund for specified purposes, including the improvement and automating of vital records maintained by the State Registrar.

This bill would terminate that account, and would specify that funds in the account shall remain in the account for expenditure upon appropriation by the Legislature.

Existing law, effective until January 1, 1997, requires the imposition of various fees for certified copies of birth or death records, marriage records, marital dissolution records, and specifies that an additional fee of $2 shall be imposed for allocation to specified accounts for modernization and improvement of public record systems and collection of the data.

This bill would extend these requirements until January 1, 1999, but would require that a fee of up to $2 shall be imposed for that purpose and would make conforming changes in the allocations.

Existing law provides for the establishment and implementation of a program of benefits for persons with acquired traumatic brain injuries, and provides that program shall remain in effect until January 1, 1997.

This bill would extend the effective date of these provisions to January 1, 2000.

Existing law requires the Director of Health Services to establish and administer a program to provide drug treatments to persons infected with human immunodeficiency virus, to the extent funds are available, and to maintain a list of drugs to be provided under the program.

This bill would require manufacturers of the drugs to pay a 15% rebate to the department for each drug, based on the average wholesale cost of the drugs. It would permit the department to adopt emergency regulations to implement

amendments to provisions relating to this program made during the 1996 portion of the 1995–96 Regular Session.

Existing law requires the Maternal and Child Health Branch of the State Department of Health Services to administer a comprehensive shelter-based services grant program for battered women.

This bill would define terms used in those provisions, would recast provisions for the implementation of the program to specify that the grants shall be administered pursuant to a request for application process, include grants for shelters that propose to maintain shelters previously granted funding, revise the schedule of areas or services for which the grants may be used, require the administration of grants to agencies to conduct demonstration projects to serve battered women that include new and innovative service approaches, revise the scope of the intent of the Legislature with respect to the provision of services in underserved communities, and authorize the Director of Health Services to award additional grants to shelter-based agencies when it is determined that there exists a critical need for shelter or shelter-based services, revise matching fund requirements, and specify minimum training requirements for appropriate staff and volunteers having client contact.

Existing law requires the State Department of Developmental Services to enter into contracts with nonprofit entities to operate regional centers for the provision of services to persons with developmental disabilities, provides for initial intake and assessment services to determine the level of service for which an applicant is eligible, and requires that, if assessment is needed, it shall be performed within a certain time period.

This bill would revise the time period during which the assessment is required to be provided.

Existing law specifies the responsibilities of regional centers for the provision of services under a contract with the State Department of Developmental Services.

This bill would revise those responsibilities.

Existing law requires the State Department of Developmental Services to establish rates for payment of community living facilities for the provision of services to

persons with developmental disabilities, and specifies that the cost of providing 24-hour care out-of-home nonmedical care and supervision in community care facilities shall be funded by the Aid to Families with Dependent Children (AFDC) program, in which counties participate financially.

This bill would specify that for the 1996–97 fiscal year, the rate schedule authorized by the department in operation June 30, 1996, shall be increased based on the amount appropriated in the Budget Act of 1996, and specifies that the increase be applied as a percentage for all contractors.

Existing law requires regional centers to submit, prior to August 1 of each year, to the State Department of Developmental Services and the State Council on Developmental Disabilities a program budget plan for the subsequent following year.

This bill would specify that regional centers shall not be subject to any law, regulation, or policy of state agencies pertaining to the planning and acquisition of information technology, and would require the State Department of Developmental Services to jointly develop guidelines with the Association of Regional Center Agencies for use by regional centers in the expenditure of funds for those information activities.

Existing law provides for the placement of certain individuals in various state hospitals for mental health treatment.

This bill would express the intent of the Legislature that persons placed for mental health treatment through criminal proceedings be placed at Atascadero State Hospital in the 1996–97 fiscal year, unless there are unique circumstances that would preclude the placement and that not more than 227 persons whose placement has been required by provisions of the Penal Code be placed in Metropolitan State Hospital in the 1996–97 fiscal year.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Services, pursuant to which medical benefits are provided to public assistance recipients and certain other low-income persons.

This bill would revise eligibility requirements for Medi-Cal benefits for families who lose eligibility for AFDC benefits due

to the reuniting of separated spouses, subject to federal financial participation.

Existing law provides for the determination of maximum allowable reimbursement rates for Medi-Cal drug treatment programs.

This bill would revise the method of calculating those maximum rates, and would require the State Department of Health Services to develop individual and group rates for extensive counseling for outpatient drug free treatment according to limitations contained in the bill.

Existing law provides for the provision of Medi-Cal benefits through contracts between the State Department of Health Services and providers for managed care services.

This bill would, until July 1, 1997, exclude hospice benefits from the scope of Medi-Cal benefits provided through specified managed care programs where the department is contracting with prepaid health plans that are contracting with, governed, owned, or operated by a county health authority.

Existing law requires the State Department of Mental Health to implement managed mental health care for Medi-Cal beneficiaries through fee-for-service or capitated rate contracts negotiated with mental health plans, including counties, counties acting jointly, any qualified individual or organization, or a nongovernmental entity.

Existing law provides for the transfer of funding and responsibility for fee-for-service mental health services from Medi-Cal managed care plans to local mental health plans and for the allocation of state funds for acute inpatient psychiatric and other mental health services, as determined by the State Department of Mental Health, and requires the provision of those services on a capitated rate upon federal approval.

Under existing law, a qualifying county may elect, with the approval of the department, to operate under the requirements of a capitated, integrated service system field test in specified circumstances.

Existing law requires the transfer of state matching funds to the State Department of Mental Health for the remaining Medi-Cal fee-for-service mental health services and the state matching funds associated with field test counties, no later

than July 1, 1996, upon agreement between the State Department of Mental Health and the State Department of Health Services.

This bill would change the date by which those remaining matching funds shall be transferred to the State Department of Mental Health from July 1, 1996, to July 1, 1997.

Existing law, until January 1, 1997, provides for the provision of drugs that are reimbursed through the Medi-Cal program without prior authorization when they are on an approved list of contract drugs, and, commencing January 1, 1997, those procedures would be revised to require the establishment of a drug formulary for prescribed drugs.

This bill would suspend until January 1, 1999, the operative date of those provisions applicable to the establishment of a drug formulary, would revise procedures for the placement of drugs on the list of contract drugs, would revise, and extend until January 1, 1999, requirements for reporting on treatment authorization requests to the Legislature, and would extend until January 1, 1999, those provisions for the use of a list of contract drugs for purposes of the Medi-Cal program.

Existing law, until January 1, 1997, requires the State Department of Health Services to report to the Legislature on the treatment authorization process.

This bill would extend the effective date of that requirement to January 1, 1997, and would require the Bureau of State Audits to prepare a report by January 1, 1998, on the drug program management techniques of the drug contracting program and the comparability of the program to other private sector third party payers.

Existing law, until January 1, 1997, authorizes the State Department of Health Services to enter into contracts with manufacturers of single-source and multiple-source drugs under the Medi-Cal program, and specifies procedures for the implementation of that authority.

This bill would extend that authority to January 1, 1999.

Existing law, until July 1, 1996, requires pharmaceutical manufacturers to provide the State Department of Health Services with a supplemental 10% rebate in addition to rebates pursuant to other provisions of law, less any state supplemental rebate provided under separate state

agreements for each prescription drug reimbursed through the Medi-Cal program.

This bill would extend that requirement until January 1, 1997.

Existing law provides for targeted case management services under the Medi-Cal program, and authorizes local agencies to implement targeted case management services, establishes local government financial contribution for the coverage of services through the targeted case management program, and, for the 1994–95 and 1995–96 fiscal years, limits the contribution to $20,000,000.

This bill would revise the contribution requirements and would extend the contribution limit indefinitely.

Existing law provides that, to the extent required under federal law, a family who was receiving Aid to Families with Dependent Children (AFDC) program benefits in at least 3 of the 6 months prior to the month the family became ineligible for assistance due to specified reasons, shall remain eligible for Medi-Cal benefits during the succeeding 6-month period.

This bill would, instead, provide that during any period for which federal financial participation is obtained, to the extent required by federal law, a family who was receiving AFDC benefits in at least 3 of the 6 months immediately preceeding the month in which that family became ineligible for that assistance due to specified reasons, shall remain eligible for Medi-Cal benefits during the immediately succeeding 6-month period.

Existing law specifies that any aged, blind, or disabled person eligible for Medi-Cal benefits immediately prior to specified maximum aid payment reductions in benefits under the State Supplementary Program for the Aged, Blind and Disabled shall not be responsible for paying his or her share of cost for Medi-Cal benefits, if he or she had that Medi-Cal eligibility without a share of costs interrupted or terminated by the maximum aid payment reductions and if he or she, but for those reductions, would be eligible to continue receiving Medi-Cal benefits without a share of costs.

This bill would extend this provision to reductions made during the 1996 portion of the 1995–96 Regular Session.

Existing law, operative until July 1, 1996, and which would be repealed on January 1, 1997, provides for state-funded perinatal services and medical services to infants up to one year of age, in families with incomes above 185%, but not more than 200% of the federal poverty level.

Existing law requires the department to provide for outreach activities in order to enhance participation and access to perinatal services, with these activities to be funded from funds appropriated for provision of these services and available federal funds.

This bill would extend those provisions indefinitely, but would eliminate the outreach activity funding provisions.

Existing law requires the State Department of Mental Health to implement managed mental health care for Medi-Cal beneficiaries through fee-for-service or capitated rate contracts with mental health plans, and specifies that emergency regulations developed to implement those provisions shall remain in effect until July 1, 1996, or until the regulations are made permanent, whichever occurs first.

This bill would extend the effective period of those regulations until July 1, 1997, or until the regulations are made permanent, whichever occurs first.

Existing law creates the child health and disability prevention program, administered by the State Department of Health Services, under which health screening and other services are provided through community child health and disability prevention programs.

The bill would require the department, by March 1, 1997, to report specified data to the Legislature concerning this program.

Existing law establishes various social services programs to prevent teenage pregnancies and assist teenage parents.

This bill would establish the Community Challenge Grant Program in the State Department of Health Services to provide community challenge grants to reduce the number of teenage and unwed pregnancies. It would require the department to administer grants to be awarded to described entities for the purpose of implementing locally developed prevention and intervention strategies. It would require the Secretary of the Health and Welfare Agency to appoint an

advisory committee to advise and consult with the department regarding the program. It would set forth requirements for grant applications, provide criteria for grant selection, and require the department to issue periodic reports that describe the projects that have been awarded grants. The bill would terminate the program on July 1, 1999, require the department to conduct an evaluation and report its findings to the Legislature on or before January 1, 1999, and repeal these provisions as of January 1, 2000.

Existing law establishes the Office of Family Planning in the State Department of Health Services, and authorizes the department to enter into contracts with agencies, institutions, and organizations to provide family planning services, as described. Existing law requires family planning services to be offered to all persons eligible for Medi-Cal benefits, to all persons eligible for public social services for which federal reimbursement is available under the federal Social Security Act, and to any persons in a family for which current social, economic, and health conditions of the family indicate that the family would likely become a recipient of financial assistance within the next 5 years. Existing law requires the office to develop and implement a sliding fee schedule for family planning services based on family size and income.

This bill would also establish the State-Only Family Planning Program in the department, to provide comprehensive clinical family planning services, as described, to low-income men and women.

The bill would require that a person is eligible to receive the services if the person is a resident of the state, has a family income at or below 200% of the federal poverty level, has no other health coverage, except as described, and is not otherwise eligible for Medi-Cal services without a share of cost. The bill would require the provider of the services to determine whether a person meets the eligibility standards. It would require an individual to sign a statement under penalty of perjury pertaining to eligibility. By changing the definition of an existing crime, this bill would impose a state-mandated local program.

The bill would authorize licensed medical personnel with family planning skills, knowledge, and competency only to

provide the full range of family planning medical services. The bill would place certain requirements on Medi-Cal enrolled providers.

The bill would require providers of the services to submit claims for reimbursement to the fiscal intermediary of the department.

The bill would set forth a grievance process.

The bill would authorize the department to adopt emergency regulations.

The bill would exempt the program from certain requirements relating to the use of contractual claims processing services.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

This bill would provide that if any provision of the bill or the application thereof to any person or circumstances is held invalid, that invalidity shall not affect other provisions or applications of the bill which can be given effect without the invalid provision or application, and to this end the provisions of this bill are severable.

This bill would declare that it is to take effect immediately as an urgency statute.

~~Existing law provides for the Medi-Cal program, administered by the State Department of Health Services, under which qualified low-income persons are provided with health care services.~~

~~This bill would express the intent of the Legislature to make the statutory changes necessary to implement the Budget Act of 1996 relative to the Medi-Cal program.~~

~~This bill would declare that it is to take effect immediately as an urgency statute.~~

Vote: $^{2}/_{3}$. Appropriation: ~~no~~ *yes*. Fiscal committee: ~~no~~ *yes*. State-mandated local program: ~~no~~ *yes*.

The people of the State of California do enact as follows:

~~SECTION 1. It is the intent of the Legislature, in enacting this act, to make the statutory changes necessary to implement the Budget Act of 1996 relative to the Medi-Cal program.~~

~~SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:~~

~~In order for this act to be implemented prior to the commencement of the 1996-97 fiscal year, this act must take effect immediately.~~

SECTION 1. The Legislature finds and declares all of the following:

(a) Various reports and investigations have documented deficiencies in pediatric emergency and critical care throughout the United States. A 1993 report from the Institute of Medicine of the National Academy of Sciences found that emergency medical services for children in the United States are inadequate. The report recommends that states develop emergency medical services systems for children within the emergency medical services system to ensure that children receive adequate and appropriate emergency medical services necessary to prevent loss of life and human potential.

(b) California has approximately two and one half million children under 14 years of age, (8.5 percent of the U.S. population, 1990 Census) within its borders, the largest pediatric population of any state in the United States. California's children experience unnecessarily high rates of injury and illness that lead to disability and death. Lifetime costs associated with fatal and nonfatal injury in 1991 were estimated at $15.3 billion for children under 15 years of age, and $100.3 billion for 15- to 24-year olds. Available estimates indicate that the implementation of comprehensive and coordinated services for emergency medical services ensures more appropriate care and an emergency medical services

system for children would provide significant economic benefits.

(c) Each year in California, approximately 240 children per 100,000 will require admission to pediatric critical care centers, yet only 55 percent of these children in need of this care actually receive it. Seventy percent of the children in pediatric care units are five years of age or less, and suffer from medical illnesses such as acute asthma, meningitis, and other infectious diseases, seizures, and poisonings. Acute illness is a source of enormous ongoing physical, psychological, and financial loss to children and families. Twenty-one thousand children die annually within the United States from these illnesses.

(d) Traumatic injuries, including, but not limited to, injuries attributed to automobiles, bicycles, burns, drowning, intentional injury or violence, and firearms are the most common cause of death in children over one year old. Statistics also show that children have an unacceptably high death rate in these emergency situations. It has been estimated that between 8,000 and 12,000 of the 22,000 children who die from injuries each year in the United States could be saved by the establishment of injury prevention programs and emergency medical services systems specifically for children.

(e) Children have unique problems and needs associated with acute injury and illness, and they also suffer from different types of injuries and illnesses than adults. As a result, children require different types of diagnostic procedures, medications, and support techniques. In order to avoid unnecessary injuries and deaths when treating children, their emergency and critical care medical needs should be recognized and treated appropriately within this state's existing emergency medical services system.

(f) Existing emergency medical services education programs primarily focus on assessment, care, and treatment of adults and offer very few hours of pediatric education. In addition, many emergency medical

services personnel have limited clinical experience with children, indicating the need to improve education of these personnel as regards pediatric emergencies.

(g) Some hospitals and out-of-hospital emergency care providers do not have the appropriate pediatric equipment to treat children in need of emergency care.

(h) Requiring pediatric preparedness in every emergency department as well as access to specialized pediatric centers would ensure that all of California's children who need emergency medical care will get appropriate pediatric emergency and critical care.

(i) The California Emergency Medical Services Authority has received national recognition for their leadership in the development of guidelines for a statewide pediatric emergency and critical care medical services model. Full implementation of the Emergency Medical Services for Children (EMSC) guidelines on a statewide basis must be achieved.

SEC. 2. Section 1797.254 of the Health and Safety Code is amended to read:

1797.254. Local EMS agencies shall annually submit an emergency medical services plan for the EMS area to the authority*, according to EMS Systems, Standards, and Guidelines established by the authority.*

SEC. 3. Chapter 12 (commencing with Section 1799.202) is added to Division 2.5 of the Health and Safety Code, to read:

CHAPTER 12. EMERGENCY MEDICAL SERVICES SYSTEM FOR CHILDREN

1799.202. This chapter shall be known and may be cited as the California Emergency Medical Services for Children Act of 1996.

1799.204. (a) For purposes of this chapter, the following definitions apply:

(1) "EMSC Program" means the Emergency Medical Services For Children Program administered by the authority.

(2) "Technical advisory committee" means a multidisciplinary committee with pediatric emergency medical services, pediatric critical care, or other related expertise.

(3) "EMSC component" means the part of the local agency's EMS plan that outlines the training, transportation, basic and advanced life support care requirements, and emergency department and hospital pediatric capabilities within a local jurisdiction.

(b) Contingent upon available funding, an Emergency Medical Services For Children Program is hereby established within the authority.

(c) The authority shall do the following to implement the EMSC Program:

(1) Employ or contract with professional, technical, research, and clerical staff as necessary to implement this chapter.

(2) Provide advice and technical assistance to local EMS agencies on the integration of an EMSC Program into their EMS system.

(3) Oversee implementation of the EMSC Program by local EMS agencies.

(4) Establish an EMSC technical advisory committee.

(5) Facilitate cooperative interstate relationships to provide appropriate care for pediatric patients who must cross state borders to receive emergency and critical care services.

(6) Work cooperatively and in a coordinated manner with the State Department of Health Services and other public and private agencies in the development of standards and policies for the delivery of emergency and critical care services to children.

(7) On or before March 1, 2000, produce a report for the Legislature describing any progress on implementation of this chapter. The report shall contain, but not be limited to, a description of the status of emergency medical services for children at both the state and local levels, the recommendation for training, protocols, and special medical equipment for emergency services for children, an estimate of the costs and benefits

of the services and programs authorized by this chapter, and a calculation of the number of children served by the EMSC system.

(d) No more than one hundred twenty thousand dollars ($120,000) per fiscal year shall be expended from the General Fund by the authority for the EMSC program.

1799.205. A local EMS agency may develop an EMSC Program in its jurisdiction, contingent upon available funding. If a local EMS agency develops an EMSC Program in its jurisdiction, the local EMS agency shall develop and incorporate in its EMS plan an EMSC component that complies with EMS plan requirements. The EMSC component shall include, but need not be limited to, the following:

(a) EMSC system planning, implementation, and management.

(b) Injury and illness prevention planning, that includes, among other things, coordination, education, and data collection.

(c) Care rendered to patients outside the hospital.

(d) Emergency department care.

(e) Interfacility consultation, transfer, and transport.

(f) Pediatric critical care and pediatric trauma services.

(g) General trauma centers with pediatric considerations.

(h) Pediatric rehabilitation plans that include, among other things, data collection and evaluation, education on early detection of need for referral, and proper referral of pediatric patients.

(i) Children with special EMS needs outside the hospital.

(j) Information management and system evaluation.

1799.207. The authority may solicit and accept grant funding from public and private sources to supplement state funds.

SEC. 4. Section 4019.10 of the Health and Safety Code is amended and renumbered to read:

~~[116565] 4019.10.~~

116565. (a) ~~Commencing January 1, 1993, until June 30, 1993, each public water system serving 200 or more service connections and any public water system that treats water on behalf of one or more public water systems for the purpose of rendering it safe for human consumption, shall reimburse the department pursuant to this section for actual costs incurred by the department for conducting those activities mandated by this chapter relating to the issuance of domestic water supply permits, inspections, monitoring, surveillance, and water quality evaluation that relate to that specific public water system. The amount of reimbursement shall be sufficient to pay, but in no event shall exceed, the department's actual cost in conducting these activities.~~

~~(b)~~ Commencing July 1, 1993, each public water system serving 1,000 or more service connections and any public water system that treats water on behalf of one or more public water systems for the purpose of rendering it safe for human consumption, shall reimburse the department for actual cost incurred by the department for conducting those activities mandated by this chapter relating to the issuance of domestic water supply permits, inspections, monitoring, surveillance, and water quality evaluation that relate to that specific public water system. The amount of reimbursement shall be sufficient to pay, but in no event shall exceed, the department's actual cost in conducting these activities.

~~(c)~~

(b) Commencing July 1, 1993, each public water system serving less than 1,000 service connections shall pay an annual drinking water operating fee to the department as set forth in this subdivision for costs incurred by the department for conducting those activities mandated by this chapter relating to inspections, monitoring, surveillance, and water quality evaluation relating to public water systems. The total amount of fees shall be sufficient to pay, but in no event shall exceed, the department's actual cost in conducting these activities. Notwithstanding adjustment of actual fees collected pursuant to Section ~~113~~ *100425* as

authorized pursuant to subdivision (d) of Section ~~4019.35~~ *106590*, the maximum amount that shall be paid annually by a public water system pursuant to this section shall not exceed the following:

Type of public water system	Fee
15– 24 service connections	$250
25– 99 service connections	$400
100–499 service connections	$500
500–999 service connections	$700
Noncommunity water systems pursuant to paragraph (1) of subdivision (j) of Section ~~4010.1~~ *116275*	$350
Noncommunity water systems exempted pursuant to Section ~~4010.35~~ *116282*	$100

~~(d)~~

(c) For purposes of determining the fees provided for in ~~subdivisions (a) and (b)~~ *subdivision (a)*, the department shall maintain a record of its actual costs for pursuing the activities specified in ~~subdivisions (a) and (b)~~ *subdivision (a)* relative to each system required to pay the fees. The fee charged each system shall reflect the department's actual cost, or in the case of a local primacy agency the local primacy agency's actual cost, of conducting the specified activities.

~~(e)~~

(d) The department shall submit an invoice for cost reimbursement for the activities specified in ~~subdivisions (a) and (b)~~ *subdivision (a) to the public water systems no more than twice a year.*

(1) The department shall submit one estimated cost invoice to public water systems serving 1,000 or more service connections and any public water system that treats water on behalf of one or more public water systems for the purpose of rendering it safe for human consumption. This invoice shall include the actual hours expended during the first six months of the fiscal year. The hourly cost rate used to determine the amount of the

estimated cost invoice shall be the rate for the previous fiscal year.

(2) The department shall submit a final invoice to the public water system prior to September 1 ~~of the fiscal year~~ following the fiscal year ~~in which~~ *that* the costs were incurred. The invoice shall indicate the total hours expended *during the fiscal year,* the reasons for the expenditure, ~~and~~ the hourly cost rate of the department *for the fiscal year, the estimated cost invoice, and payments received. The amount of the final invoice shall be determined using the total hours expended during the fiscal year and the actual hourly cost rate of the department for the fiscal year. The payment of the estimated invoice, exclusive of late penalty, if any, shall be credited toward the final invoice amount.*

(3) Payment of the invoice *issued pursuant to paragraphs (1) and (2)* shall be made within ~~120~~ *90* days of the date of the invoice. Failure to pay the amount of the invoice within ~~120~~ *90* days shall result in a 10 percent late penalty that shall be paid in addition to the ~~fee~~ *invoiced amount*.

~~(f)~~

(e) Any public water system under the jurisdiction of a local primacy agency shall pay the fees specified in this section to the local primacy agency in lieu of the department. This section shall not preclude a local health officer from imposing additional fees pursuant to Section ~~510~~ *101325*.

SEC. 5. Section 102247 of the Health and Safety Code is amended to read:

102247. (a) There is hereby created in the State Treasury the Health Statistics Special Fund. The fund shall consist of revenues including, but not limited to, all of the following:

(1) Fees or charges remitted to the State Registrar for record search or issuance of certificates, permits, registrations, or other documents pursuant to Chapter 3 (commencing with Section 26800) of Part 3 of Division 2 of Title 3 of the Government Code, and Chapter 4 (commencing with Section 102525), Chapter 5

(commencing with Section 102625), Chapter 8 (commencing with Section 103050), and Chapter 15 (commencing with Section 103600), of Part 1, of Division 102.

(2) Funds remitted to the State Registrar by the federal Social Security Administration for participation in the enumeration at birth program.

(3) Funds remitted to the State Registrar by the National Center for Health Statistics pursuant to the federal Vital Statistics Cooperative Program.

(4) Funds deposited ~~into the Vital Records Improvement Account~~ pursuant to Section 103640.

(5) Any other funds collected by the State Registrar, except Children's Trust Fund fees collected pursuant to Section 18966 of the Welfare and Institutions Code, fees allocated to the Judicial Council pursuant to Section 1852 of the Family Code, and fees collected pursuant to Section 103645, all of which shall be deposited into the General Fund.

(b) Moneys in the Health Statistics Special Fund shall be expended by the State Registrar for the purpose of funding its existing programs and programs that may become necessary to carry out its mission, upon appropriation by the Legislature.

(c) Health Statistics Special Fund moneys shall be expended only for the purposes set forth in this section and Section 102249, and shall not be expended for any other purpose or for any other state program.

(d) It is the intent of the Legislature that the Health Statistics Special Fund provide for the following:

(1) Registration and preservation of vital event records and dissemination of vital event information to the public.

(2) Data analysis of vital statistics for population projections, health trends and patterns, epidemiologic research, and development of information to support new health policies.

(3) Development of uniform health data systems that are integrated, accessible, and useful in the collection of information on health status.

~~(e) This section shall become operative on July 1, 1995.~~

SEC. 6. Section 102250 of the Health and Safety Code is amended to read:

102250. (a) *(1)* There is a State Vital Record Improvement Account in the Health Statistics Special Fund.

(2) Commencing January 1, 1997, the State Vital Record Improvement Account in the Health Statistics Special Fund shall be terminated and all funds in the State Vital Record Improvement Account in the Health Statistics Special Fund, or owed to that account as of January 1, 1997, shall remain in the Health Statistics Special Fund and may be expended, upon appropriation by the Legislature, for the purposes of the act adding this paragraph or to fulfill other statutory requirements of the State Registrar.

(b) The remainder of the moneys in the account that are not subject to local allocations on ~~July 1, 1995~~ *January 1, 1997*, pursuant to subdivision (a) of former Section 10040, shall, *upon appropriation by the Legislature*, be utilized by the State Registrar to improve and automate the processing of vital records maintained by the State Registrar.

(c) This section shall become operative ~~July 1, 1995~~ *January 1, 1997*.

SEC. 7. Section 103640 is added to the Health and Safety Code, to read:

103640. (a) In addition to the fees prescribed by subdivisions (a) to (d), inclusive, of Section 103625, all applicants for certified copies of the records described in those subdivisions shall pay an additional fee of up to two dollars ($2), that shall be collected by the State Registrar, the local registrar, county recorder, or county clerk, as the case may be.

(b) Except as provided in paragraph (2), the local public official charged with the collection of the additional fee established pursuant to subdivision (a) may create a Vital and Health Statistics Trust Fund. The fees collected by local public officials pursuant to subdivision (a) shall be distributed as follows:

(1) Up to ninety cents ($0.90) of each fee collected pursuant to this section shall be deposited with the State Registrar for deposit pursuant to Section 102250.

(2) The remainder of the fee collected pursuant to this section shall be deposited into the collecting agency's Vital and Health Statistics Trust Fund.

(3) Any local public official that does not establish a local Vital and Health Statistics Trust Fund shall forward the entire fee collected pursuant to this section to the State Registrar, who shall deposit the fees pursuant to Section 102250.

(4) Fees collected by the State Registrar shall be deposited pursuant to Section 102250.

(c) Moneys in each Vital and Health Statistics Trust Fund shall be available to the public official charged with the collection of fees pursuant to this section to defray the administrative costs of collecting and reporting with respect to those fees and for the other costs, as follows:

(1) Modernization of vital record operations, including improvement, automation, and technical support of vital record systems.

(2) Improvement in the collection and analysis of health-related birth and death certificate information, and other community health data collection and analysis, as appropriate.

(d) Funds collected pursuant to this section shall not be used to supplant existing funding that is necessary for the daily operation of vital record systems. It is the intent of the Legislature that funds collected pursuant to this section be used to enhance service to the public, to improve analytical capabilities of state and local health authorities in addressing the health needs of newborn children, maternal health problems, and to analyze the health status of the general population.

(e) Each county shall annually submit a report to the State Registrar by March 1, containing information on the amount of revenues collected pursuant to this section for the previous calendar year and on how the revenues were expended and for what purpose.

(f) This section shall remain in effect only until January 1, 1999, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 1999, deletes or extends that date.

(g) This section shall become operative on January 1, 1997.

SEC. 8. Section 116377 is added to the Health and Safety Code, to read:

116377. The department may adopt emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, to implement amendments to this chapter. The initial adoption of emergency regulations and one readoption of the initial regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Initial emergency regulations and the first readoption of those regulations shall be exempt from review by the Office of Administrative Law. The emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations and shall remain in effect for not more than 180 days.

SEC. 9. Section 116590 of the Health and Safety Code is amended to read:

116590. (a) All funds received by the department pursuant to this chapter, including, but not limited to, all civil penalties collected by the department pursuant to Article 9 (commencing with Section 116650) and Article 11 (commencing with Section 116725), shall be deposited into the Safe Drinking Water Account that is hereby established. Funds in the Safe Drinking Water Account may not be expended for any purpose other than as set forth in this chapter. ~~Notwithstanding Section 13340 of the Government Code, funds~~ *All moneys* collected by the department pursuant to Sections 116565 to 116600, inclusive, ~~and~~ *shall be* deposited into the Safe Drinking Water Account ~~are continuously appropriated without~~

~~regard to fiscal year to pay the expenses of the department~~ *for use by the department, upon appropriation by the Legislature, for the purpose of providing funds necessary* to administer this chapter.

(b) The department's hourly cost rate used to determine the reimbursement for actual costs pursuant to Sections 116565, 116577, and 116580 shall be based upon the department's salaries, benefits, travel expense, operating, equipment, administrative support, and overhead costs.

(c) Notwithstanding Section 6103 of the Government Code, each public water system operating under a permit issued pursuant to this chapter shall pay the fees set forth in this chapter. A public water system shall be permitted to collect a fee from its customers to recover the fees paid pursuant to this chapter.

(d) The fees collected pursuant to subdivision ~~(c)~~ *(b)* of Section 116565 and subdivision (b) of Section 116570 shall be adjusted annually pursuant to Section 100425, and the adjusted fee amounts shall be rounded off to the nearest whole dollar.

(e) Fees assessed pursuant to this chapter shall not exceed actual costs to either the department or the local primacy agency, as the case may be, related to the public water systems assessed the fees.

(f) In no event shall the total amount of funds collected pursuant to~~ subdivisions (a) and (b)~~ *subdivision (a)* of Section 116565, and subdivision (a) of Section 116577 from public water systems serving 1,000 or more service connections exceed the following:

(1) For the 1992–93 fiscal year, four million nine hundred thousand dollars ($4,900,000).

(2) For the 1993–94 fiscal year, four million seven hundred fifty thousand dollars ($4,750,000).

(3) For the 1994–95 fiscal year, five million dollars ($5,000,000).

(4) For the 1995–96 fiscal year, five million two hundred fifty thousand dollars ($5,250,000).

(5) For the 1996–97 fiscal year, five million five hundred thousand dollars ($5,500,000).

(6) For the 1997–98 fiscal year and subsequent fiscal years, the total amount of funds collected shall not increase by more than 5 percent of the amount collected for the previous fiscal year.

(g) The department shall develop a time accounting standard designed to do all of the following:

(1) Provide accurate time accounting.

(2) Provide accurate invoicing based upon hourly rates comparable to private sector professional classifications and comparable rates charged by other states for comparable services. These rates shall be applied against the time spent by the actual individuals who perform the work.

(3) Establish work standards that address work tasks, timing, completeness, limits on redirection of effort, and limits on the time spent in the aggregate for each activity.

(4) Establish overhead charge-back limitations, including, but not limited to, charge-back limitations on charges relating to reimbursement of services provided to the department by other departments and agencies of the state, that reasonably relate to the performance of the function.

(5) Provide appropriate invoice controls.

SEC. 10. Section 116600 of the Health and Safety Code is amended to read:

116600. Except as otherwise specified, Sections 116565 to 116600, inclusive, shall become operative July 1, 1993. Sections 116565 to 116600, inclusive, shall remain in effect until January 1, ~~1997~~ *2002*, and as of that date are repealed unless a later enacted statute that is enacted before January 1, ~~1997~~ *2002*, deletes or extends that date.

SEC. 11. Section 120955 of the Health and Safety Code is amended to read:

120955. (a) To the extent that state and federal funds are appropriated in the Budget Act for these purposes, the director shall establish and may administer a program to provide drug treatments to persons infected with human immunodeficiency virus (HIV), the etiologic agent of acquired immune deficiency syndrome (AIDS). The director shall develop, maintain, and update as

necessary a list of drugs to be provided under this program. Drugs on the list shall include, but not be limited to, the drugs zidovudine (AZT) and aerosolized pentamidine.

(b) The director may grant funds to a county public health department through standard agreements to administer this program in that county. To maximize the recipients' access to drugs covered by this program, the director shall urge the county health department in counties granted these funds to decentralize distribution of the drugs to the recipients.

(c) The director shall establish a rate structure for reimbursement for the cost of each drug included in the program. Rates shall not be less than the actual cost of the drug. However, the director may purchase a listed drug directly from the manufacturer and negotiate the most favorable bulk price for that drug.

(d) *Manufacturers of the drugs on the list shall pay the department a rebate of 15 percent of the average wholesale cost price of each drug.*

(e) The department shall submit an invoice, not less than two times per year, to each manufacturer for the amount of the rebate required by subdivision (d).

(f) Drugs may be removed from the list for failure to pay the rebate required by subdivision (d), unless the department determines that removal of the drug from the list would cause substantial medical hardship to beneficiaries.

(g) The department may adopt emergency regulations to implement amendments to this chapter made during the 1996 portion of the 1995–96 Regular Session, in accordance with the Administrative Procedure Act, Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The initial adoption of emergency regulations shall be deemed to be an emergency and considered by the Office of Administrative Law as necessary for the immediate preservation of the public peace, health and safety, or general welfare. Emergency regulations

adopted pursuant to this section shall remain in effect for no more than 180 days.

(h) Reimbursement under this chapter shall not be made for any drugs that are available to the recipient under any other private, state, or federal programs, or under any other contractual or legal entitlements, except that the director may authorize an exemption from this subdivision where exemption would represent a cost savings to the state.

SEC. 12. Section 123227 of the Health and Safety Code is amended to read:

123227. (a) *The following definitions shall apply for purposes of this section:*

(1) "Domestic violence" means the infliction or threat of physical harm against past or present adult or adolescent female intimate partners, and shall include physical, sexual, and psychological abuse against the woman, and is a part of a pattern of assaultive, coercive, and controlling behaviors directed at achieving compliance from or control over, that woman.

(2) "Shelter-based" means an established system of services where battered women and their children may be provided safe or confidential emergency housing on a 24-hour basis, including, but not limited to, hotel or motel arrangements, haven, and safe houses.

(3) "Emergency shelter" means a confidential or safe location that provides emergency housing on a 24-hour basis for battered women and their children.

(b) The Maternal and Child Health Branch of the State Department of Health Services shall administer a comprehensive shelter-based services grant program to battered women's shelters pursuant to this section.

~~(b)~~

(c) The Maternal and Child Health Branch shall administer grants*, awarded as the result of a request for application process,* to battered women's shelters that propose *to maintain shelters or services previously granted funding pursuant to this section,* to expand existing services or create new services, and to establish

new battered women's shelters to provide services, in any of the following four areas:

(1) Emergency shelter to women and their children escaping violent family situations.

(2) Transitional housing programs to help women and their children find housing and jobs so that they are not forced to choose between returning to a violent relationship or becoming homeless. The programs may offer up to 18 months of housing, case management, job training and placement, counseling, support groups, and classes in parenting and family budgeting.

(3) Legal and other types of advocacy and representation to help women and their children pursue the appropriate legal options.

(4) Other support services for battered women ~~identified by the advisory council, including, but not limited to, creative and innovative service approaches such as community response teams~~ *and their children*.

~~(c)~~

(d) In implementing the grant program pursuant to this section, the State Department of Health Services shall consult with an advisory council, to remain in existence until January 1, ~~1996~~ *1998*. The council shall be composed of not to exceed 13 voting members and two nonvoting members appointed as follows:

(1) Seven members appointed by the Governor.

(2) Three members appointed by the Speaker of the Assembly.

(3) Three members appointed by the Senate Committee on Rules.

(4) Two nonvoting ex officio members who shall be Members of the Legislature, one appointed by the Speaker of the Assembly and one appointed by the Senate Committee on Rules. Any Member of the Legislature appointed to the council shall meet with, and participate in the activities of, the council to the extent that participation is not incompatible with his or her position as a Member of the Legislature.

The membership of the council shall consist of domestic violence advocates, battered women service providers,

and representatives of women's organizations, law enforcement, and other groups involved with domestic violence. At least one-half of the council membership shall consist of domestic violence advocates or battered women service providers from organizations such as the California Alliance Against Domestic Violence.

It is the intent of the Legislature that the council membership reflect the ethnic, racial, cultural, and geographic diversity of the state.

~~(d)~~

(e) The department shall collaborate closely with the council in the development of funding priorities, the framing of the Request for Proposals, and the solicitation of proposals.

~~(e) Administrative costs of the State Department of Health Services incurred pursuant to the grant program shall not exceed 5 percent of the funds allocated for the program.~~

~~(f) The shelters funded pursuant to this section shall reflect the ethnic, racial, economic, cultural, and geographic diversity of the state. It~~

(f) (1) The Maternal and Child Health Branch of the State Department of Health Services shall administer grants, awarded as the result of a request for application process, to agencies to conduct demonstration projects to serve battered women, including, but not limited to, creative and innovative service approaches, such as community response teams and pilot projects to develop new interventions emphasizing prevention and education, and other support projects identified by the advisory council.

(2) For purposes of this subdivision, "agency" means a state agency, a local government, a community-based organization, or a nonprofit organization.

(g) It is the intent of the Legislature that services funded by this program include services in underserved and ~~minority~~ *ethnic and racial* communities. *Therefore, the Maternal and Child Health Branch of the State Department of Health Services shall do all of the following:*

(1) Fund shelters pursuant to this section that reflect the ethnic, racial, economic, cultural, and geographic diversity of the state.

(2) Target geographic areas and ethnic and racial communities of the state whereby, based on a needs assessment, it is determined that no shelter-based services exist or that additional resources are necessary.

(h) The director may award additional grants to shelter-based agencies when it is determined that there exists a critical need for shelter or shelter-based services.

(i) As a condition of receiving funding pursuant to this section, battered women's shelters shall ~~provide~~ *do all of the following:*

(1) Provide matching funds or in-kind contributions equivalent to ~~10~~ *not less than 20* percent of the grant they would receive. The matching funds or in-kind contributions may come from other governmental or private sources.

~~(h) The State Department of Health Services shall issue a Request for Proposals and shall encumber the funds or complete negotiations for agreements no later than May 1, 1995.~~

(2) Ensure that appropriate staff and volunteers having client contact meet the definition of "domestic violence counselor" as specified in subdivision (a) of Section 1037.1 of the Evidence Code. The minimum training specified in paragraph (2) of subdivision (a) of Section 1037.1 of the Evidence Code shall be provided to those staff and volunteers who do not meet the requirements of paragraph (1) of subdivision (a) of Section 1037.1 of the Evidence Code.

SEC. 13. Section 123228 is added to the Health and Safety Code, to read:

123228. (a) The Maternal and Child Health Branch of the State Department of Health Services shall fund, through a competitive selection process determined by the director, at least one agency to provide expert technical assistance and training on domestic violence issues and building agency capacity in order to obtain other funding for services for battered women and their

children, including, but not limited to, grant writing and building coalitions.

(b) The Maternal and Child Health Branch of the State Department of Health Services shall fund at least one agency to conduct a statewide evaluation of the services funded through Section 123277.

(c) For purposes of subdivision (a), "agency" means a state agency, local government, a community-based organization, or a nonprofit agency.

(d) Contracts awarded pursuant to this section are exempt from the competitive bidding requirements of the Public Contract Code.

SEC. 14. Section 4359 of the Welfare and Institutions Code is amended to read:

4359. This chapter shall remain in effect until January 1, ~~1997~~ *2000*, and as of that date is repealed, unless a later enacted statute enacted prior to that date extends or deletes that date.

SEC. 15. Section 4643 of the Welfare and Institutions Code, as amended by Chapter 1 of the 1996 Fourth Extraordinary Session, is amended to read:

4643. (a) If assessment is needed, it shall be performed within 120 days following initial intake. Assessment shall be performed ~~within~~ *as soon as possible and in no event more than* 60 days following initial intake where any delay would expose the client to unnecessary risk to his or her health and safety or to significant further delay in mental or physical development, or the client would be at imminent risk of placement in a more restrictive environment. Assessment may include collection and review of available historical diagnostic data, provision or procurement of necessary tests and evaluations, and summarization of developmental levels and service needs *and is conditional upon receipt of the release of information specified in subdivision (b)*. On ~~November~~ *July* 1, ~~1996~~ *2000*, the 120 days allowed for assessment shall revert to 60 days and if unusual circumstances prevent the completion of assessment within 60 days following intake, this assessment period

may be extended by one 30-day period with the advance written approval of the department.

(b) In determining if an individual meets the definition of developmental disability contained in subdivision (a) of Section 4512, the regional center may consider evaluations and tests, including, but not limited to, intelligence tests, adaptive functioning tests, neurological and neuropsychological tests, diagnostic tests performed by a physician, psychiatric tests, and other tests or evaluations that have been performed by, and are available from, other sources.

SEC. 16. Section 4681.3 is added to the Welfare and Institutions Code, to read:

4681.3. Notwithstanding any other provision of this article, for the 1996–97 fiscal year, the rate schedule authorized by the department in operation June 30, 1996, shall be increased based upon the amount appropriated in the Budget Act of 1996 for that purpose. The increase shall be applied as a percentage, and the percentage shall be the same for all providers.

SEC. 17. Section 4776.5 is added to the Welfare and Institutions Code, to read:

4776.5. (a) Regional centers shall not be subject to any provision of law, regulation, or policy required of state agencies pertaining to the planning and acquisition of information technology, including personal computers, local area networks, information technology consultation, and software.

(b) The State Department of Developmental Services and the Association of Regional Center Agencies shall jointly develop guidelines for use by regional centers in the expenditure of funds for those information system activities, including consultation and software development, involving interface with the data bases of the State Department of Developmental Services, including the Uniform Fiscal System.

SEC. 18. Section 4791 of the Welfare and Institutions Code, as amended by Chapter 1 of the 1996 Fourth Extraordinary Session, is amended to read:

4791. (a) The Legislature finds that *when* the state faces an unprecedented fiscal crisis ~~and that~~, the services set forth in this division are necessary to enable persons with developmental disabilities to live in the least restrictive setting.

(b) In order to ensure that services to eligible consumers are available throughout the ~~contract period~~ *fiscal year*, regional centers shall administer their contracts within the level of funding available within the annual Budget Act.

(c) To carry out the intent of this provision, and notwithstanding Chapter 5 and Section 4643, each regional center contract shall include provisions which ensure the regional center will provide services to eligible consumers within the funds available in the contract throughout the ~~contract term~~ *fiscal year.* Regional centers shall implement innovative, cost-effective methods of services delivery, which may include, but not be limited to, the use of vouchers, consumer or parent services coordinators, increased administrative efficiencies, and alternative sources of payment for services.

(d) ~~In the event that there is an unallocated budget reduction in the total regional center budget during the 1992–93 fiscal year, which does not exceed forty million eight hundred thousand dollars ($40,800,000) in the total regional center budget, not less than 40 percent of the reduction shall be used to reduce the regional center operations budget line item with the remainder of the reduction applied to the regional center purchase of services budget line item.~~

~~(e) In the event that there is an unallocated regional center budget reduction that exceeds forty million eight hundred thousand dollars ($40,800,000) in the total regional center budget in the 1992–93 fiscal year the initial forty million eight hundred thousand dollars ($40,800,000) of the reduction shall be applied pursuant to subdivision (d) above, with the remainder of the reduction applied 25 percent to the regional center operations budget line item with the remainder of the~~

~~reduction applied to the regional center purchase of services budget line item.~~

~~(f) The~~ *In the event of an unallocated reduction, the* Budget Act of each fiscal year ~~from 1993-94 to 1995-96, inclusive, and through October 31, 1996,~~ shall determine the distribution of any unallocated reduction within the regional center budget item.

~~(g) On or before July 15, of each fiscal year the~~

(e) In the event of an unallocated reduction in the regional center budget, or if an individual regional center notifies the department that the regional center will be unable to provide services and supports to eligible consumers throughout the fiscal year within the level of funding available in their contract, the following shall apply:

(1) The department shall provide *the regional center or* regional centers with *guidelines, technical assistance, and* a variety of options for reducing operations and ~~service~~ *purchase of service* costs.

~~(h)~~

(2) Within 30 days of the enactment of the Budget Act *or after the date a regional center notifies the department of a projected deficit in its purchase of services budget,* each *impacted* regional center shall develop and submit a plan to the department describing in detail how it intends to absorb any unallocated reduction and shall achieve savings necessary to provide services to eligible consumers throughout the ~~contract term~~ *fiscal year* within the limitations of the funds allocated. Prior to adopting the plan, each regional center shall hold a public hearing in order to receive comment on the plan. The regional centers shall provide notice to the community at least 10 days in advance of the public hearing. *The regional center shall summarize and respond to the public testimony in their plan.*

~~(1)~~

(3) The plan submitted to the department may include, but not be limited to:

(A) Innovative and cost-effective methods of services delivery that include, but are not limited to, the use of

vouchers; the use of consumers and parents as service coordinators; alternative methods of case management; the use of volunteer teams, made up of consumers, parents, other family members, and advocates, to conduct the monitoring activities described in Section 4648.1; increased administrative efficiencies; alternative sources of payment for services; use of available assessments in determining eligibility; and alternative nonresidential rate methodologies or service delivery models, or both. In addition, the regional center shall take into account, in identifying the consumer's service needs, the family's responsibility for providing similar services to a child without disabilities.

(B) The maximization of all alternative funding sources, including federal and generic funding sources.

(C) Assurances that all other operations expenditure reductions are considered before any reductions are made in nonsupervisory, service coordination staff.

~~(2)~~

(4) The regional centers shall implement components of their plans upon approval of the department. The department shall review and approve, or require modification of portions of the regional centers' plan, within 30 days of receipt of the plan.

~~(i)~~

(f) Notwithstanding any other provision of law, *in any fiscal year in which an unallocated reduction is made in the regional center budget,* the ~~Director of Developmental Services~~ *director* may adopt, amend, repeal, or suspend regulations as necessary to permit program flexibility and allow regional centers to achieve cost savings or innovative approaches to service delivery, including, but not limited, to those specified in subparagraph (A) of paragraph (1) of subdivision ~~(g)~~ *(e)* without adversely affecting consumer health and safety or placing persons with disabilities in a more restrictive environment. Furthermore, any such regulatory change shall not authorize categorical reductions; changes in service delivery shall have an exemption process. It is the intent of the Legislature that any such action be deemed

an emergency necessary for the immediate preservation of the public peace, health, and safety, or general welfare for purposes of subdivision (b) of Section 11346.1 of the Government Code.

~~(j)~~

(g) Notwithstanding any other provision of law, the State Director of the Department of Developmental Services may require one or more regional centers to take any actions he or she determines to be necessary to ensure reductions are made in the regional center operations budget, including, but not limited to, the following:

(1) Require a regional center to centralize billing and other fiscal and administrative functions.

(2) Require a regional center to reduce office space through the decentralization of service coordinators by allowing service coordinators to work in their homes and in community-based programs.

(3) Require a regional center to freeze or reduce levels of pay for administrative and managerial employees.

(4) Require a regional center to contract for specified functions currently conducted directly by the regional center.

(5) Require regional centers to seek Medi-Cal provider status for regional center staff performing reimbursable activities.

~~(k)~~

(h) Notwithstanding any other provisions of law, the director may terminate a regional center contract if he or she determines that the regional center is unable or unwilling to make the necessary reductions in its operations budget or if the action is necessary to avoid reductions in the purchase of services for regional center consumers.

~~(l)~~

(i) Notwithstanding any other provisions of law, the department may directly operate a regional center after the termination of a contract.

~~(m)~~

(j) If the director determines that regional centers cannot provide services throughout the ~~contract term~~ *fiscal year* within the funds provided by the Budget Act, he or she shall immediately report to the Governor and the appropriate fiscal committees of the Legislature and recommend actions to secure additional funds or reduce expenditures, including any actions which require the suspension of the entitlement to service set forth in this division.

~~(n)~~

(k) Developing and implementing the plan shall be considered a contractual obligation pursuant to Section 4635 of the Welfare and Institutions Code. Accordingly, the department shall make reasonable efforts to assist regional centers in fulfilling their contractual obligations and provide technical assistance, as necessary. In addition, a regional center's failure to develop and implement the plan may be considered grounds for contract termination or nonrenewal. If at any time the director of the department determines that a regional center's plan does not adequately address a funding deficiency during the ~~contract period~~ *fiscal year*, the director may require the use of operational funds to reduce the deficiency in purchase of services funds.

~~(o)~~

(l) This section shall become inoperative on July 1, 2000, and, as of January 1, 2001, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2001, deletes or extends the dates on which it becomes inoperative and is repealed. ~~This section shall remain operative only until November 1, 1996, shall remain in effect only until January 1, 1997, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 1997, deletes or extends that date.~~

SEC. 19. Section 5778 of the Welfare and Institutions Code is amended to read:

5778. (a) This section shall be limited to mental health services reimbursed through a fee-for-service payment system.

(b) During the initial phases of the implementation of this part, as determined by the department, the mental health plan contractor and subcontractors shall submit claims under the Medi-Cal program for eligible services on a fee-for-service basis.

(c) A qualifying county may elect, with the approval of the department, to operate under the requirements of a capitated, integrated service system field test pursuant to Section 5719.5 rather than this part, in the event the requirements of the two programs conflict. A county that elects to operate under that section shall comply with all other provisions of this part that do not conflict with that section.

(d) (1) No sooner than October 1, 1994, state matching funds for Medi-Cal fee-for-service acute psychiatric inpatient services, and associated administrative days, shall be transferred to the department. No later than July 1, ~~1996~~ *1997*, upon agreement between the department and the State Department of Health Services, state matching funds for the remaining Medi-Cal fee-for-service mental health services and the state matching funds associated with field test counties under Section 5719.5 shall be transferred to the department.

(2) The State Department of Mental Health, in consultation with the State Department of Health Services, a statewide organization representing counties, and a statewide organization representing health maintenance organizations shall develop a timeline for the transfer of funding and responsibility for fee-for-service mental health services from Medi-Cal managed care plans to local mental health plans. In developing the timeline, the department shall develop screening, referral, and coordination guidelines to be used by Medi-Cal managed care plans and local mental health plans.

(e) The department shall allocate the contracted amount at the beginning of the contract period to the mental health plan. The allocated funds shall be considered to be funds of the plan that may be held by the

department. The department shall develop a methodology to ensure that these funds are held as the property of the plan and shall not be reallocated by the department or other entity of state government for other purposes.

(f) Beginning in the fiscal year following the transfer of funds from the State Department of Health Services, the state matching funds for Medi-Cal mental health services shall be included in the annual budget for the State Department of Mental Health. The amount included shall be based on historical cost, adjusted for changes in the number of Medi-Cal beneficiaries and other relevant factors.

(g) Initially, the mental health plans shall use the fiscal intermediary of the Medi-Cal program of the State Department of Health Services for the processing of claims for inpatient psychiatric hospital services and may be required to use that fiscal intermediary for the remaining mental health services. The providers for other Short-Doyle Medi-Cal services shall not be initially required to use the fiscal intermediary but may be required to do so on a date to be determined by the department. The department and its mental health plans shall be responsible for the initial incremental increased matching costs of the fiscal intermediary for claims processing and information retrieval associated with the operation of the services funded by the transferred funds.

(h) The mental health plans, subcontractors, and providers of mental health services shall be liable for all federal audit exceptions or disallowances based on their conduct or determinations. The mental health plan contractors shall not be liable for federal audit exceptions or disallowances based on the state's conduct or determinations. The department and the State Department of Health Services shall work jointly with mental health plans in initiating any necessary appeals. The State Department of Health Services may offset the amount of any federal disallowance or audit exception against subsequent claims from the mental health plan or subcontractor. This offset may be done at any time, after

the audit exception or disallowance has been withheld from the federal financial participation claim made by the State Department of Health Services. The maximum amount that may be withheld shall be 25 percent of each payment to the plan or subcontractor.

(i) The mental health plans shall have sufficient funds on deposit with the department as the matching funds necessary for federal financial participation to ensure timely payment of claims for acute psychiatric inpatient services and associated administrative days. The department and the State Department of Health Services, in consultation with a statewide organization representing counties, shall establish a mechanism to facilitate timely availability of those funds. Any funds held by the state on behalf of a plan shall be deposited in a mental health managed care deposit fund and shall accrue interest to the plan. The department shall exercise any necessary funding procedures pursuant to Section 12419.5 of the Government Code and Sections 8776.6 and 8790.8 of the State Administrative Manual regarding county claim submission and payment.

(j) (1) The goal for funding of the future capitated system shall be to develop statewide rates for beneficiary, by aid category and with regional price differentiation, within a reasonable time period. The formula for distributing the state matching funds transferred to the State Department of Mental Health for acute inpatient psychiatric services to the participating counties shall be based on the following principles:

(A) Medi-Cal state General Fund matching dollars shall be distributed to counties based on historic Medi-Cal acute inpatient psychiatric costs for the county's beneficiaries and on the number of persons eligible for Medi-Cal in that county.

(B) All counties shall receive a baseline based on historic and projected expenditures up to October 1, 1994.

(C) Projected inpatient growth for the period October 1, 1994, to June 30, 1995, inclusive, shall be distributed to counties below the statewide average per eligible person on a proportional basis. The average shall

be determined by the relative standing of the aggregate of each county's expenditures of mental health Medi-Cal dollars per beneficiary. Total Medi-Cal dollars shall include both fee-for-service Medi-Cal and Short-Doyle Medi-Cal dollars for both acute inpatient psychiatric services, outpatient mental health services, and psychiatric nursing facility services, both in facilities that are not designated as institutions for mental disease and for beneficiaries who are under 22 years of age and beneficiaries who are over 64 years of age in facilities that are designated as institutions for mental disease.

(D) There shall be funds set aside for a self-insurance risk pool for small counties. For purposes of this subdivision, ''small counties'' means counties with less than 200,000 population.

(2) The allocation method for state funds transferred for acute inpatient psychiatric services shall be as follows:

(A) For the 1994–95 fiscal year, an amount equal to 0.6965 percent of the total shall be transferred to a fund established by small counties. This fund shall be used to reimburse mental health plans in small counties for the cost of acute inpatient psychiatric services in excess of the funding provided to the mental health plan for risk reinsurance, acute inpatient psychiatric services and associated administrative days, or for costs associated with the administration of these moneys. The methodology for use of these moneys shall be determined by the small counties, through a statewide organization representing counties, in consultation with the State Department of Mental Health.

(B) The balance of the transfer amount for the 1994–95 fiscal year shall be allocated to counties based on the following formula:

County	Percentage
Alameda	3.5991
Alpine	.0050
Amador	.0490
Butte	.8724
Calaveras	.0683

Colusa	.0294
Contra Costa	1.5544
Del Norte	.1359
El Dorado	.2272
Fresno	2.5612
Glenn	.0597
Humboldt	.1987
Imperial	.6269
Inyo	.0802
Kern	2.6309
Kings	.4371
Lake	.2955
Lassen	.1236
Los Angeles	31.3239
Madera	.3882
Marin	1.0290
Mariposa	.0501
Mendocino	.3038
Merced	.5077
Modoc	.0176
Mono	.0096
Monterey	.7351
Napa	.2909
Nevada	.1489
Orange	8.0627
Placer	.2366
Plumas	.0491
Riverside	4.4955
Sacramento	3.3506
San Benito	.1171
San Bernardino	6.4790
San Diego	12.3128
San Francisco	3.5473
San Joaquin	1.4813
San Luis Obispo	.2660
San Mateo	.0000
Santa Barbara	.0000
Santa Clara	1.9284
Santa Cruz	1.7571

Shasta	.3997
Sierra	.0105
Siskiyou	.1695
Solano	.0000
Sonoma	.5766
Stanislaus	1.7855
Sutter/Yuba	.7980
Tehama	.1842
Trinity	.0271
Tulare	2.1314
Tuolumne	.2646
Ventura	.8058
Yolo	.4043

(k) The allocation method for the state funds transferred for subsequent years for acute inpatient psychiatric and other mental health services shall be determined by the State Department of Mental Health in consultation with a statewide organization representing counties.

(*l*) The allocation methodologies described in this section shall only be in effect while federal financial participation is received on a fee-for-service reimbursement basis. When federal funds are capitated, the State Department of Mental Health, in consultation with a statewide organization representing counties, shall determine the methodology for capitation consistent with federal requirements.

(m) The formula that specifies the amount of state matching funds transferred for the remaining Medi-Cal fee-for-service mental health services shall be determined by the department in consultation with a statewide organization representing counties. This formula shall only be in effect while federal financial participation is received on a fee-for-service reimbursement basis.

(n) Upon the transfer of funds from the budget of the State Department of Health Services to the department pursuant to subdivision (d), the department shall assume the applicable program oversight authority formerly

provided by the State Department of Health Services, including, but not limited to, the oversight of utilization controls as specified in Section 14133. The mental health plan shall include a requirement in any subcontracts that all inpatient subcontractors maintain necessary licensing and certification. Mental health plans shall require that services delivered by licensed staff are within their scope of practice. Nothing in this part shall prohibit the mental health plans from establishing standards that are in addition to the minimum federal and state requirements, provided that these standards do not violate federal and state Medi-Cal requirements and guidelines.

(o) Subject to federal approval and consistent with state requirements, the mental health plan may negotiate rates with providers of mental health services.

(p) Under the fee-for-service payment system, any excess in the payment set forth in the contract over the expenditures for services by the plan shall be spent for the provision of mental health services and related administrative costs.

(q) Nothing in this part shall limit the mental health plan from being reimbursed appropriate federal financial participation for any qualified services even if the total expenditures for service exceeds the contract amount with the Department of Mental Health. Matching nonfederal public funds shall be provided by the plan for the federal financial participation matching requirement.

SEC. 20. Section 6600.05 is added to the Welfare and Institutions Code, to read:

6600.05. It is the intent of the Legislature that persons committed to a secure facility for mental health treatment pursuant to Section 6600 shall be placed at Atascadero State Hospital in the 1996–97 fiscal year unless there are unique circumstances that would preclude the placement of a person at that facility.

SEC. 21. Section 7200.05 is added to the Welfare and Institutions Code, to read:

7200.05. It is the intent of the Legislature that not more than 227 patients whose placement has been

required pursuant to provisions of the Penal Code shall be placed in Metropolitan State Hospital in the 1996–97 fiscal year.

SEC. 22. Section 14005.21 of the Welfare and Institutions Code is amended to read:

14005.21. (a) Any medically needy aged, blind, or disabled person who was categorically needy under this chapter on the basis of eligibility under Chapter 3 (commencing with Section 12000) or Subchapter 16 (commencing with Section 1381) of Chapter 7 of Title 42 of the United States Code for the month of August 1993, and was discontinued as of September 1, 1993, and who, but for the addition of Section 12200.015, would be eligible to receive benefits without a share of cost in September 1993 under this chapter, shall remain eligible to receive benefits without a share of cost under this chapter as if that person were categorically needy as long as he or she meets other applicable requirements.

(b) Any medically needy aged, blind, or disabled person who was eligible for benefits under this chapter as categorically needy or medically needy under subdivision (a) for the month of August 1994, shall not be responsible for paying his or her share of cost if he or she had that eligibility for benefits without a share of cost interrupted or terminated by the addition of Section 12200.017, and if he or she, but for Section 12200.017, would be eligible to continue receiving benefits under this chapter without a share of cost.

(c) Any medically needy aged, blind, or disabled person who was eligible for benefits under this chapter as categorically needy, or as medically needy under subdivision (a) or (b), for the calendar month immediately preceding the date that the reductions in maximum aid payments for the state supplementary program established in Chapter 3 (commencing with Section 12000) of Part 3 of Division 9 made in the 1995–96 Regular Session of the Legislature are effective shall not be responsible for paying his or her share of cost if he or she had that eligibility for benefits without a share of cost interrupted or terminated by the reductions in maximum

aid payments, and if he or she, but for the reductions, would be eligible to continue receiving benefits under this chapter without a share of cost.

(d) *Any medically needy aged, blind, or disabled person who was eligible for benefits under this chapter as categorically needy, or as medically needy under subdivisions (a), (b), or (c) for the calendar month immediately preceding the date that the reductions in maximum aid payments for the state supplementary program established in Chapter 3 (commencing with Section 12000) made in the 1996 portion of the 1995-96 Regular Session of the Legislature are effective shall not be responsible for paying his or her share of cost if he or she had that eligibility for benefits without a share of cost interrupted or terminated by the reductions in maximum aid payments, and if he or she, but for these reductions, would be eligible to continue receiving benefits under this chapter without a share of cost.*

(e) The department shall implement this section regardless of the availability of federal financial participation for the share of cost paid from state funds pursuant to subdivisions (a), (b), ~~and~~ (c), *and (d)*.

SEC. 23. Section 14005.8 of the Welfare and Institutions Code is amended to read:

14005.8. (a) (1) To the extent required by ~~subchapter~~ *Subchapter* XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code and regulations adopted pursuant thereto, a family who was receiving aid pursuant to a state plan approved under Part A of Subchapter IV (commencing with Section 601) of Title 42 of the United States Code in at least three of the six months immediately preceding the month in which that family became ineligible for that assistance due to increased hours of employment, income from employment, or the loss of earned income disregards, shall remain eligible for health care services as provided in this chapter during the immediately succeeding six-month period.

(2) The department shall terminate extensions of health care services authorized by paragraph (1) as required under federal law.

(b) The department shall notify persons eligible under subdivision (a) of their right to continued health care services for each six-month period and a description of their reporting requirement, and the circumstances under which the extension may be terminated. The notice shall also include a Medi-Cal card or other evidence of entitlement to those services.

(c) Notwithstanding any other provision of this section, the department, in conformance with federal law, shall offer beneficiaries covered under subdivision (a) the option of remaining eligible for health care services provided in this chapter for an additional extension period of six months. Health services shall be continued in as automatic a manner as permitted by federal law, and without any unnecessary paperwork.

(d) During the initial extension period and any additional six-month extension period, the department, consistent with federal law, may, whenever the department determines it to be cost-effective, elect to pay a family's expenses for premiums, deductibles, coinsurance, or similar costs for health insurance or other health coverage offered by an employer of the caretaker relative or by an employer of the absent parent of the dependent child. If, during the additional six-month extension period, the department elects to pay health premiums and this coverage exists, the beneficiary may be given the opportunity to express his or her preference between continuing the Medi-Cal coverage or obtaining health insurance.

(e) During the additional six-month extension period, the department may impose a premium for the health insurance or other health coverage consistent with Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) if the department determines that the imposition of a premium is cost-effective.

(f) The department shall adopt emergency regulations in order to comply with mandatory provisions

of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) for extension of medical assistance. These regulations shall become effective immediately upon filing with the Secretary of State.

(g) This section shall become operative April 1, 1990.

(h) This section shall become inoperative only if, and commencing on the date that, the director executes a declaration, that shall be retained by the director, stating that any federal approval required for federal financial participation in the provision of transitional Medi-Cal benefits pursuant to Section 14005.81, as added during the 1996 portion of the 1995-96 Regular Session, has been obtained, and shall remain inoperative until Section 14005.81 is repealed or the director executes a declaration, that shall be retained by the director, stating that federal financial participation has been withdrawn, whichever occurs first.

SEC. 24. Section 14005.81 is added to the Welfare and Institutions Code, to read:

14005.81. (a) (1) To the extent required by Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code and regulations adopted pursuant to that subchapter, a family who was receiving aid pursuant to a state plan approved under Part A (commencing with Section 601) of Subchapter IV of Title 42 of the United States Code in at least three of the six months immediately preceding the month in which that family became ineligible for that assistance due to increased hours of employment, income from employment, or the loss of earned income disregards, shall remain eligible for health care services as provided in this chapter during the immediately succeeding 6-month period.

(2) The department shall terminate extensions of health care services authorized by paragraph (1) as required under federal law.

(b) The department shall notify each person eligible under subdivision (a) of his or her right to continued health care services for each 6-month period, and shall provide him or her with a description of his or her

reporting obligation, and the circumstances under which the extension may be terminated. The notice shall also include a Medi-Cal card or other evidence of entitlement to those services.

(c) Notwithstanding any other provision of this section, the department, in conformance with federal law, shall offer beneficiaries covered under this subdivision (a) the option of remaining eligible for health care services provided in this chapter for up to three additional extension periods of six months each.

(d) Health services shall be continued in as automatic a manner as permitted by federal law, and without any unnecessary paperwork.

(e) During the initial extension period and any additional 6-month extension period, the department, consistent with federal law, may, whenever the department determines it to be cost effective, elect to pay a family's expenses for premiums, deductibles, coinsurance, or similar costs for health insurance or other health coverage offered by an employer of the caretaker relative or by an employer of the absent parent of the dependent child. If, during any additional 6-month extension period, the department elects to pay health premiums and this coverage exists, the beneficiary may be given the opportunity to express his or her preference between continuing the Medi-Cal coverage or obtaining health insurance.

(f) During any additional 6-month extension period, the department may impose a premium for the health insurance or other health coverage consistent with Title XIX of the federal Social Security Act (Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code) if the department determines that the imposition of a premium is cost effective.

(g) The department shall, in accordance with the Administrative Procedure Act, Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, adopt emergency regulations in order to comply with the requirement set forth in this section for extension of medical assistance.

These regulations shall become effective immediately upon filing with the Secretary of State.

(h) No later than October 1, 1996, the director shall seek approval from the United States Department of Health and Human Services for federal financial participation in the implementation of this section.

(i) This section shall become operative only if, and to the extent that, the director executes a declaration that shall be retained by the director, stating that any necessary federal approvals have been obtained and that federal financial participation under Title XIX of the federal Social Security Act, if applicable, has been approved.

SEC. 25. Section 14005.85 of the Welfare and Institutions Code is amended to read:

14005.85. (a) Families who, because of marriage or because separated spouses reunite, lose AFDC eligibility under the chapter because the family no longer meets the need requirement specified in Section 11250 or has increased assets or income, or both, shall be eligible for extended medical benefits as specified under ~~Section 14005.8~~ *this article for a period not to exceed 12 months*.

(b) The department shall seek all federal waivers necessary to implement this section.

(c) This section shall not be implemented until the director has executed a declaration, that shall be retained by the director, that any necessary waivers and federal financial participation have been obtained.

SEC. 26. Section 14021.6 of the Welfare and Institutions Code is amended to read:

14021.6. (a) Subject to the requirements of federal law, the maximum allowable rates for the Medi-Cal Drug Treatment Program shall be determined by computing the median rate from available cost data by modality from the fiscal year that is two years prior to the year for which the rate is being established.

(b) ~~Utilizing the criteria in subdivision (a), the department shall develop individual and group rates for extensive counseling for outpatient drug free treatment, based on a 50-minute individual or a 90-minute group~~

~~hour, not to exceed the total rate established for outpatient drug free services. The per person group rate shall be established as a fraction of the group rate.~~

~~(c)~~ *Notwithstanding subdivision (a), for the 1996–97 fiscal year, the rates for nonperinatal outpatient methadone maintenance services shall be set at the rate established for the 1995–96 fiscal year.*

(c) Notwithstanding subdivision (a), the maximum allowable rate for group outpatient drug free services shall be set on a per person basis. A group shall consist of a minimum of four and a maximum of ten individuals, at least one of which shall be a Medi-Cal eligible beneficiary.

(d) The department shall develop individual and group rates for extensive counseling for outpatient drug free treatment, based on a 50 minute individual or a 90 minute group hour, not to exceed the total rate established for subdivision (c).

(e) The department may adopt regulations as necessary to implement subdivisions (a) and (b), or to implement cost containment procedures. These regulations may be adopted as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The adoption of these emergency regulations shall be deemed an emergency necessary for the immediate preservation of the public peace, health and safety, or general welfare.

SEC. 27. Section 14087.305 is added to the Welfare and Institutions Code, to read:

14087.305. (a) In areas specified by the director for expansion of the Medi-Cal managed care program under 14087.3 and where the department is contracting with prepaid health plans or with prepaid health plans that are contracting with, governed, owned, or operated by a county board of supervisors, a county special commission or county health authority authorized by Section 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, and 14087.96, the department shall exclude the Medi-Cal hospice benefit from the list of covered services for which it contracts.

(b) This section shall not apply to managed care contracts signed or in place on July 1, 1996, and any contract in the 12 expansion counties. Medi-Cal beneficiaries eligible for the hospice benefit, and who elect the benefit, shall be provided with the name, address, and telephone number of each licensed hospice provider in their geographic area.

(c) The name, address, and telephone number of each participating hospice shall be made available by contacting the health care options contractor or the health care plan.

(d) Each beneficiary or eligible appliant electing the benefit shall be informed that if he or she fails to make a choice, he or she shall be assigned to, and enrolled in a hospice.

(e) This section shall become inoperative on July 1, 1997, and, as of January 1, 1998, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 1998, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 28. Section 14105.31 of the Welfare and Institutions Code is amended to read:

14105.31. For purposes of the Medi-Cal contract drug list, the following definitions shall apply:

(a) ''Single-source drug'' means a drug that is produced and distributed under an original New Drug Application approved by the federal Food and Drug Administration. This shall include a drug marketed by the innovator manufacturer and any cross-licensed producers or distributors operating under the New Drug Application, and shall also include a biological product, except for vaccines, marketed by the innovator manufacturer and any cross-licensed producers or distributors licensed by the federal Food and Drug Administration pursuant to Section 262 of Title 42 of the United States Code. A drug ceases to be a single-source drug when the same drug in the same dosage form and strength manufactured by another manufacturer is approved by the federal Food and Drug Administration

under the provisions for an Abbreviated New Drug Application.

(b) ‘‘Best price’’ means the negotiated price, or the manufacturer’s lowest price available to any class of trade organization or entity, including, but not limited to, wholesalers, retailers, hospitals, repackagers, providers, or governmental entities within the United States, that contracts with a manufacturer for a specified price for drugs, inclusive of cash discounts, free goods, volume discounts, rebates, and on- or off-invoice discounts or credits, shall be based upon the manufacturer’s commonly used retail package sizes for the drug sold by wholesalers to retail pharmacies.

(c) ‘‘Equalization payment amount’’ means the amount negotiated between the manufacturer and the department for reimbursement by the manufacturer, as specified in the contract. The equalization payment amount shall be based on the difference between the manufacturer’s direct catalog price charged to wholesalers and the manufacturer’s best price, as defined in subdivision (b).

(d) ‘‘Manufacturer’’ means any person, partnership, corporation, or other institution or entity that is engaged in the production, preparation, propagation, compounding, conversion, or processing of drugs, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, or in the packaging, repackaging, labeling, relabeling, and distribution of drugs.

(e) ‘‘Price escalator’’ means a mutually agreed upon price specified in the contract, to cover anticipated cost increases over the life of the contract.

(f) ‘‘Medi-Cal pharmacy costs’’ or ‘‘Medi-Cal drug costs’’ means all reimbursements to pharmacy providers for services or merchandise, including single-source or multiple-source prescription drugs, over-the-counter medications, and medical supplies, or any other costs billed by pharmacy providers under the Medi-Cal program.

(g) This section shall remain in effect only until January 1, ~~1997~~ *1999*, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, ~~1997~~ *1999*, deletes or extends that date.

SEC. 29. Section 14105.33 of the Welfare and Institutions Code is amended to read:

14105.33. (a) The department may enter into contracts with manufacturers of single-source and multiple-source drugs, on a bid or nonbid basis, for drugs from each major therapeutic category, and shall maintain a list of those drugs for which contracts have been executed. It is the intent of the Legislature that, in the implementation of this section during the~~—1992–93~~ *1996–97* fiscal year, the director negotiate as aggressively as necessary to achieve the savings related to pharmaceutical contracting identified in the Budget Act of ~~1992 (Chapter 587 of the Statutes of 1992)~~ *1996*.

(b) (1) Contracts executed pursuant to this section shall be for the manufacturer's best price, as defined in Section 14105.31, which shall be specified in the contract, and subject to agreed upon price escalators, as defined in that section. The contracts shall provide for an equalization payment amount, as defined in Section 14105.31, to be remitted to the department quarterly. The department shall submit an invoice to each manufacturer for the equalization payment amount, based on utilization data from the department's prescription drug paid claims tapes. The drugs of any manufacturer with an existing contract that does not execute a contract amendment with the department within 60 days of the effective date of the amendment of this section enacted in 1992, pursuant to the requirements of this subdivision as amended, or a manufacturer without an existing contract that does not execute a contract with the department within 60 days of the effective date of this amendment of this section enacted in 1992, pursuant to the requirements of this subdivision as amended, shall be available to Medi-Cal beneficiaries only through prior authorization.

(2) The department shall provide for an annual audit of utilization data used to calculate the equalization amount to verify the accuracy of that data. The findings of the audit shall be documented in a written audit report to be made available to manufacturers within 90 days of receipt of the report from the auditor. Any manufacturer may receive a copy of the audit report upon written request. Contracts between the department and manufacturers shall provide for any equalization payment adjustments determined necessary pursuant to an audit.

(3) Utilization data used to determine an equalization payment amount shall exclude data from both of the following:

(A) Health maintenance organizations, as defined in Section 300e(a) of Title 42 of the United States Code, including those organizations that contract under Section 1396b(m) of Title 42 of the United States Code.

(B) Capitated plans that include a prescription drug benefit in the capitated rate, and that have negotiated contracts for rebates or discounts with manufacturers.

(c) In order that Medi-Cal beneficiaries may have access to a comprehensive range of therapeutic agents, the department shall ensure that there is representation on the list of contract drugs in all major therapeutic categories. Except as provided in subdivision (a) of Section 14105.35, the department shall not be required to contract with all manufacturers who negotiate for a contract in a particular category. The department shall ensure that there is sufficient representation of single-source and multiple-source drugs, as appropriate, in each major therapeutic category.

(d) (1) The department shall select the therapeutic categories to be included on the list of contract drugs, and the order in which it seeks contracts for those categories. The department may establish different contracting schedules for single-source and multiple-source drugs within a given therapeutic category.

(2) The department shall make every attempt to complete the initial contracting process for each major therapeutic category by January 1, ~~1997~~ *1999*.

(e) (1) In order to fully implement subdivision (d), the department shall, to the extent necessary, negotiate or renegotiate contracts to ensure there are as many single-source drugs within each therapeutic category or subcategory as the department determines necessary to meet the health needs of the Medi-Cal population. The department may determine in selected therapeutic categories or subcategories that no single-source drugs are necessary because there are currently sufficient multiple-source drugs in the therapeutic category or subcategory on the list of contract drugs to meet the health needs of the Medi-Cal population. However, in no event shall a beneficiary be denied continued use of a drug which is part of a prescribed therapy in effect as of September 2, 1992, until the prescribed therapy is no longer prescribed.

(2) In the development of decisions by the department on the required number of single-source drugs in a therapeutic category or subcategory, and the relative therapeutic merits of each drug in a therapeutic category or subcategory, the department shall consult with the Medi-Cal Contract Drug Advisory Committee. The committee members shall communicate their comments and recommendations to the department within ~~10~~ *30* business days of a request for consultation, and shall disclose any associations with pharmaceutical manufacturers or any remuneration from pharmaceutical manufacturers.

(3) In order to expedite implementation of paragraph (1), the requirements of Sections 14105.37, 14105.38, subdivisions (a), (c), (e), and (f) of Sections 14105.39, 14105.4, and 14105.405 are waived for the purposes of this section until January 1, 1994.

(f) In order to achieve maximum cost savings, the Legislature declares that an expedited process for contracts under this section is necessary. Therefore, contracts entered into on a nonbid basis shall be exempt

from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(g) In no event shall a beneficiary be denied continued use of a drug that is part of a prescribed therapy in effect as of September 2, 1992, until the prescribed therapy is no longer prescribed.

(h) Contracts executed pursuant to this section shall be confidential and shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(i) The department shall provide individual notice to Medi-Cal beneficiaries at least 60 calendar days prior to the effective date of the deletion or suspension of any drug from the list of contract drugs. The notice shall include a description of the beneficiary's right to a fair hearing and shall encourage the beneficiary to consult a physician to determine if an appropriate substitute medication is available from Medi-Cal.

(j) In carrying out the provisions of this section, the department may contract either directly, or through the fiscal intermediary, for pharmacy consultant staff necessary to initially accomplish the treatment authorization request reviews. ~~This authority shall extend for a maximum of 18 months from the date of the initial contract.~~

(k) This section shall remain in effect only until January 1, ~~1997~~ *1999*, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, ~~1997~~ *1999*, deletes or extends that date.

SEC. 30. Section 14105.335 is added to the Welfare and Institutions Code, to read:

14105.335. (a) Effective July 1, 1996, all pharmaceutical manufacturers shall provide the department a supplemental 10 percent rebate in addition to rebates pursuant to other provisions of state or federal law, less any state supplemental rebate currently provided under separate state agreements. The supplemental rebate required under this section shall be required for each prescription drug reimbursed through

the Medi-Cal program. This supplemental rebate shall be calculated as 10 percent of the manufacturer's average manufacturer price, as that term is defined in the manufacturer's contract with the Health Care Financing Administration pursuant to Section 1927 of the Social Security Act (42 U.S.C. 1396r-8). Products that have been added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2 do not require a supplemental rebate.

(b) Until such time as a manufacturer executes a contract or contract amendment for the rebates required by subdivision (a), all of that manufacturer's drugs and drug products shall be available to Medi-Cal beneficiaries only through prior authorization.

(c) In carrying out this section, the department may contract either directly, or through the fiscal intermediary, for pharmacy consultant staff necessary to accomplish the treatment authorization request reviews. This authority shall extend until January 1, 1997.

(d) For any drug placed on prior authorization pursuant to subdivision (b), the procedural and notification requirements described in subdivision (i) of Section 14105.33, Sections 14105.37 and 14105.38, subdivisions (a), (c), (e), and (f) of Section 14105.39, and Sections 14105.4 and 14105.405 are waived for the purposes of this section.

(e) This section shall remain in effect only until January 1, 1997, and as of that date, is repealed, unless a later enacted statute that is enacted on or before January 1, 1997, deletes or extends that date.

SEC. 31. Section 14105.35 of the Welfare and Institutions Code is amended to read:

14105.35. (a) (1) On and after July 1, 1990, drugs included on the Medi-Cal drug formulary shall be included on the list of contract drugs until the department and the manufacturer have concluded contract negotiations or the department suspends the drug from the list of contract drugs pursuant to the provisions of this subdivision.

The department shall, in writing, invite any manufacturer with single-source drug products on the formulary as of July 1, 1990, to enter into negotiations relative to the retention of its drug or drugs. As to the issue of cost, the department shall accept the manufacturer's best price as sufficient for purposes of entering into a contract to retain the drug or drugs on the list of contract drugs.

If the department and a manufacturer enter into a contract for retention of a drug or drugs on the list of contract drugs, the drug or drugs shall be retained on the list of contract drugs for the effective term of the contract.

If a manufacturer refuses to enter into negotiations with the department pursuant to this subdivision, or if after 30 days of negotiation, the manufacturer has not agreed to execute a contract for a drug at the manufacturer's best price, the department may suspend from the list of contract drugs the manufacturer's single-source drug in question for a period of at least 180 days. The department shall lift the suspension upon execution of a contract for that drug. Consistent with the provisions of this section, the department shall delete the Medi-Cal drug formulary specified in paragraphs (b), (c), (d), and (e) of Section 59999 of Title 22 of the California Code of Regulations.

(2) On and after July 1, 1990, the director may retain a drug on the Medi-Cal list of contract drugs even if no contract is executed with a manufacturer, if the director determines that an essential need exists for that drug, and there are no other drugs currently on the formulary that meet that need.

(3) The director may delete a drug from the list of contract drugs if the director determines that the drug presents problems of safety or misuse. The director's decision as to safety shall be based upon published medical literature, and the director's decision as to misuse shall be based on published medical literature and claims data supplied by the fiscal intermediary.

(b) Any reference to the Medi-Cal drug formulary by statute or regulation shall be construed as referring to the list of contract drugs.

(c) (1) Any drug in the process of being added to the formulary by contract agreement pursuant to Section 14105.3, executed prior to the effective date of this section, shall be added to the list of contract drugs.

(2) Contracts pursuant to Section 14105.3 executed prior to January 1, 1991, shall be considered to be contracts executed pursuant to Section 14105.33, and the department shall exempt the drugs included in these contracts from the initial therapeutic category review in which they would normally be considered.

(3) Nothing in this section shall be construed to require the department to discontinue negotiations into which it has entered with any manufacturer as of the effective date of this section. Contracts entered into as a result of these negotiations shall be exempt from the initial therapeutic category review in which they would normally be considered.

(d) This section shall remain in effect only until January 1, ~~1997~~ *1999*, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, ~~1997~~ *1999*, deletes or extends that date.

SEC. 32. Section 14105.37 of the Welfare and Institutions Code is amended to read:

14105.37. (a) The department shall notify each manufacturer of drugs in therapeutic categories selected pursuant to Section 14105.33 of the provisions of Sections 14105.31 to 14105.42, inclusive.

(b) If, within ~~30~~ *45* days of notification, a manufacturer does not enter into negotiations for a contract pursuant to those sections, the department may suspend or delete from the list of contract drugs, or refuse to consider for addition, drugs of that manufacturer in the selected therapeutic categories.

(c) If, after ~~120~~ *150* days from the initial notification, a contract is not executed for a drug currently on the list of contract drugs, the department may suspend or delete the drug from the list of contract drugs.

(d) If, within ~~120~~ *150* days from the initial notification, a contract is executed for a drug currently on the list of contract drugs, the department shall retain the drug on the list of contract drugs.

(e) If, within ~~120~~ *150* days from the date of the initial notification, a contract is executed for a drug not currently on the list of contract drugs, the department shall add the drug to the list of contract drugs.

(f) The department shall terminate all negotiations ~~120~~ *150* days after the initial notification.

(g) The department may suspend or delete any drug from the list of contract drugs at the expiration of the contract term or when the contract between the department and the manufacturer of that drug is terminated.

(h) Any drug suspended from the list of contract drugs pursuant to this section or Section 14105.35 shall be subject to prior authorization, as if that drug were not on the list of contract drugs.

(i) Any drug suspended from the list of contract drugs pursuant to this section or Section 14105.35 for at least 12 months may be deleted from the list of contract drugs in accordance with the provisions of Section 14105.38.

(j) This section shall remain in effect only until January 1, ~~1997~~ *1999*, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, ~~1997~~ *1999*, deletes or extends that date.

SEC. 33. Section 14105.38 of the Welfare and Institutions Code is amended to read:

14105.38. (a) (1) In the event the department determines a drug should be deleted from the list of contract drugs, the department shall conduct a public hearing, as provided in this section, to receive comment on the impact of removing the drug.

(2) (A) The department shall provide written notice 30 days prior to the hearing.

(B) The department shall send the notice required by this subdivision to the manufacturer of the drug proposed to be deleted and to organizations representing Medi-Cal beneficiaries.

(b) (1) The hearing panel shall consist of the Chief, Medi-Cal Drug Discount Program, who shall serve as chair, and the Medi-Cal Contract Drug Advisory Committee.

(2) The hearing shall be recorded and transcribed, and the transcript available for public review.

(3) Subsequent to hearing all public comment, and within 30 days of the hearing, each panel member shall submit a recommendation regarding deletion of the drug and the reason for the recommendation to the director.

(c) The director shall consider public comments provided at the hearing and the recommendations of each panel member in determining whether to delete the drug.

(d) This section shall remain in effect only until January 1, ~~1997~~ *1999*, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, ~~1997~~ *1999*, deletes or extends that date.

SEC. 34. Section 14105.39 of the Welfare and Institutions Code is amended to read:

14105.39. (a) (1) A manufacturer of a new single-source drug may request inclusion of its drug on the list of contract drugs pursuant to Section 14105.33 provided all of the following conditions are met:

(A) The request is made within ~~18~~ *12* months of approval for marketing by the federal Food and Drug Administration.

(B) The manufacturer agrees to negotiate a contract with the department to provide the drug at the manufacturer's best price.

(C) (i) The manufacturer provides the department with necessary information, as specified by the department, in the request.

(ii) Notwithstanding clause (i), either of the following may be submitted by the manufacturer in lieu of the Summary Basis of Approval prepared by the federal Food and Drug Administration for that drug:

(I) The federal Food and Drug Administration's approval or approvable letter for the drug and federal Food and Drug Administration's approved labeling.

(II) The federal Food and Drug Administration's medical officers' and pharmacologists' reviews and the federal Food and Drug Administration's approved labeling.

(D) The department had concluded contracting for the therapeutic category in which the drug is included prior to approval of the drug by the federal Food and Drug Administration.

(2) Within 90 days from receipt of the request, the department shall evaluate the request using the criteria identified in subdivision (d), and shall submit the drug to the Medi-Cal Contract Drug Advisory Committee.

(b) Any petition for the addition to or deletion of a drug to the Medi-Cal drug formulary submitted prior to July 31, 1990, shall be deemed to be denied. A manufacturer who has submitted a petition deemed denied may request inclusion of that drug on the list of contract drugs provided all of the following conditions are met:

(1) The manufacturer agrees to negotiate for a contract with the department to provide the drug at the manufacturer's best price.

(2) The manufacturer provides the department with necessary information, as specified by the department, in the request.

(3) The manufacturer submits the request to the department prior to October 1, 1990.

(c) Any new drug designated as having an important therapeutic gain and approved for marketing by the federal Food and Drug Administration on or after July 31, 1990, shall immediately be included on the list of contract drugs for a period of three years provided that all of the following conditions are met:

(1) The manufacturer offers the department its best price.

(2) The drug is typically administered in an outpatient setting.

(3) The drug is prescribed only for the indications and usage specified in the federal Food and Drug Administration approved labeling.

(4) The drug is determined by the director to be safe, relative to other drugs in the same therapeutic category on the list of contract drugs.

(d) (1) To ensure that the health needs of Medi-Cal beneficiaries are met consistent with the intent of this chapter, the department shall, when evaluating a decision to execute a contract, and when evaluating drugs for retention on, addition to, or deletion from, the list of contract drugs, use all of the following criteria:

(A) The safety of the drug.

(B) The effectiveness of the drug.

(C) The essential need for the drug.

(D) The potential for misuse of the drug.

(E) The cost of the drug.

(2) The deficiency of a drug when measured by one of these criteria may be sufficient to support a decision that the drug should not be added or retained, or should be deleted from the list. However, the superiority of a drug under one criterion may be sufficient to warrant the addition or retention of the drug, notwithstanding a deficiency in another criterion.

(e) (1) A manufacturer of single-source drugs denied a contract pursuant to this section or Section 14105.33 or 14105.37, may file an appeal of that decision with the director within 30 calendar days of the department's written decision.

(2) Within 30 calendar days of the manufacturer's appeal, the director shall request a recommendation regarding the appeal from the Medi-Cal Contract Drug Advisory Committee. The committee shall provide its recommendation in writing, within 30 calendar days of the director's request.

(3) The director shall issue a final decision on the appeal within 30 calendar days of the recommendation.

(f) ~~Changes~~ *Deletions* made to the list of contract drugs, including those made pursuant to Section 14105.37, shall become effective no sooner than 30 days after publication of the changes in provider bulletins.

(g) Changes made to the list of contract drugs under this or any other section are exempt from the

requirements of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Chapter 4 (commencing with Section 11370), and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), and shall not be subject to the review and approval of the Office of Administrative Law.

(h) This section shall remain in effect only until January 1, ~~1997~~ *1999*, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, ~~1997~~ *1999*, deletes or extends that date.

SEC. 35. Section 14105.4 of the Welfare and Institutions Code, as amended by Section 8 of Chapter 723 of the Statutes of 1992, is amended to read:

14105.4. (a) The director shall appoint a Medi-Cal Contract Drug Advisory Committee for the purpose of providing scientific and medical analysis on drugs contained on the list of contract drugs. The duties of the committee shall be as follows:

(1) To review drugs in the Medi-Cal list of contract drugs and make written recommendations to the director as to the addition of any drug or the deletion of any drug from the list. These recommendations shall be in accordance with subdivision (d) of Section 14105.39.

(2) To review and report in writing to the director as to the comparative therapeutic effect of drugs in accordance with Section 14053.5.

(3) To prepare a fair, impartial, and independent recommendation in writing, regarding appeals from manufacturers made pursuant to subdivision (e) of Section 14105.39.

(b) The committee shall consist of at least one representative from each of the following groups:

(1) Physicians.

(2) Pharmacists.

(3) Schools of pharmacy or pharmacologists.

(4) ~~Med-Cal~~ *Medi-Cal* beneficiaries.

(c) Members of the committee shall be reimbursed for necessary travel and other expenses incurred in the performance of official committee duties.

(d) In order to provide sufficient scientific information and analysis in the therapeutic categories under review, the director may replace a representative if required for specific expertise.

(e) The director shall notify the committee of the decisions made on the recommendations.

(f) This section shall remain in effect only until January 1, ~~1997~~ *1999*, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, ~~1997~~ *1999*, deletes or extends that date.

SEC. 36. Section 14105.4 of the Welfare and Institutions Code, as amended by Section 9 of Chapter 723 of the Statutes of 1992, is amended to read:

14105.4. (a) The department shall schedule and conduct a public regulatory hearing to consider the addition of a drug to, or the deletion of a drug from, the Medi-Cal drug formulary five working days subsequent to the Medical Therapeutic and Drug Advisory Committee meeting which shall meet at least every four months. The public hearing may consist of written testimony only, and the hearing record shall be closed at the end of the public hearing.

(b) The department shall make available 45 days prior to the public hearing the department's estimate of any anticipated costs or savings to the state from adding a drug product to, or deleting a drug product from, the Medi-Cal drug formulary.

(c) Whenever the department accepts a completed petition to add a drug product to the Medi-Cal drug formulary and it is not processed pursuant to Section 14105.9, it shall be scheduled for review at the next regularly scheduled Medical Therapeutic and Drug Advisory Committee meeting and public regulatory hearing, unless the meeting and hearing are scheduled to occur within 120 days, in which case the drug product may be scheduled for the following hearing.

(d) The director shall issue a final decision regarding the drug product and shall submit any regulation adding a drug product to, or deleting a drug product from, the Medi-Cal drug formulary to the Office of Administrative

Law, along with the completed rulemaking record, within seven months after the hearing prescribed in subdivision (a). This section shall not, however, be construed in a manner which results in the disapproval or invalidation of a regulation for failure to comply with the timeframes prescribed in this subdivision and subdivisions (a) and (c).

(e) (1) Except as provided in paragraph (2), the criteria used by the department in deciding whether a drug product shall be added to or deleted from the formulary shall be limited to the criteria adopted as department regulations. The criteria shall be specific and unambiguous.

(2) Notwithstanding paragraph (1), either of the following may be submitted by the manufacturer in lieu of the Summary Basis of Approval prepared by the federal Food and Drug Administration for that drug:

(A) The federal Food and Drug Administration's approval or approvable letter for the drug and federal Food and Drug Administration's approved labeling.

(B) The federal Food and Drug Administration's medical officers' and pharmacologists' reviews and the federal Food and Drug Administration's approved labeling.

(f) Departmental requests for information from persons filing drug petitions to which this section applies shall be specific and unambiguous and shall be made solely for the purpose of addressing the criteria utilized in accordance with subdivision (e).

(g) All published studies received by the department pursuant to a drug petition prior to the close of the public regulatory hearing record shall be accepted and considered by the department.

(h) Whenever the director decides to reject a petition to add a drug product to, or delete a drug product from, the formulary, the director shall notify the petitioner directly and in writing indicating the reason and specifying the criteria utilized in reaching the decision.

(i) The department shall accept a petition for a drug that has been rejected by the director upon the

submission of another complete petition containing substantial new information that addresses the reason or reasons for rejection stated by the director pursuant to subdivision (h). Any petition accepted pursuant to this subdivision shall be processed in accordance with subdivision (c), or Section 14105.9, whichever is applicable.

(j) This section shall become operative on January 1, ~~1997~~ *1999*.

SEC. 37. Section 14105.405 of the Welfare and Institutions Code is amended to read:

14105.405. (a) A Medi-Cal beneficiary, within 90 days of receipt of the director's notice to beneficiaries pursuant to subdivision (g) of Section 14105.33, informing them of the decision to delete or suspend a drug from the list of contract drugs, may request a fair hearing pursuant to Chapter 7 (commencing with Section 10950) of Part 2.

(b) Any beneficiary filing a fair hearing request regarding the deletion or suspension of a drug from the formulary shall be granted a treatment authorization request for that drug until a final decision is adopted by the director. Should the beneficiary seek judicial review of the director's decision, a treatment authorization request shall be granted for that drug until a final decision is issued by the court.

(c) (1) Any Medi-Cal beneficiary, within one year of the director's decision pursuant to Section 10959, may file a petition with the superior court, under the provisions of Section 1094.5 of the Code of Civil Procedure, praying for a review of both the legal and factual basis for the director's decision.

(2) The director shall be the sole respondent in these proceedings.

(d) Any Medi-Cal beneficiary injured as a result of being denied a drug which is determined to be medically necessary may sue for injunctive or declaratory relief to review the director's decision to delete or suspend a drug from the list of contract drugs.

(e) This section shall remain in effect only until January 1, ~~1997~~ *1999*, and as of that date is repealed, unless

a later enacted statute, which is enacted before January 1, ~~1997~~ *1999*, deletes or extends that date.

SEC. 38. Section 14105.41 of the Welfare and Institutions Code, as amended by Section 11 of Chapter 723 of the Statutes of 1992, is amended to read:

14105.41. (a) Moneys accruing to the department from contracts executed pursuant to Section 14105.33 shall be deposited in the Health Care Deposit Fund, and shall be subject to appropriation by the Legislature.

(b) This section shall remain in effect only until January 1, ~~1997~~ *1999*, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, ~~1997~~ *1999*, deletes or extends that date.

SEC. 39. Section 14105.41 of the Welfare and Institutions Code, as amended by Section 97 of Chapter 938 of the Statutes of 1995, is amended to read:

14105.41. (a) For the purpose of adding drugs to, or deleting drugs from, the Medi-Cal drug formulary as described in Section 14105.4, whether pursuant to a petition or by the department independent of a petition, all of the requirements of the Administrative Procedure Act contained in Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code shall be applicable except that the requirements of subdivision (a) of Section 11340.7 and subdivision (a) of Section 11346.9 of the Government Code shall be deemed to have been complied with if the department does all of the following:

(1) Upon receipt of a petition requesting the addition of a drug to, or the deletion of a drug from, the Medi-Cal drug formulary, the department shall notify the petitioner directly and in writing of the receipt of the petition and shall, within 30 days, either return the petition as incomplete or schedule the petition for public hearing, unless the public hearing is not required pursuant to Section 14105.9.

(2) Notifies each petitioner directly and in writing of its decision regarding the addition of a drug product to, or deletion of a drug product from, the formulary and shall state the reason or reasons for its decision and the

specific regulatory criteria that are the basis of the department's decision.

(3) Prepares and submits to the Office of Administrative Law with the adopted regulation all of the following for each drug which the department has decided to add to, or delete from, the Medi-Cal drug formulary:

(A) A brief summary of the comments submitted. For the purpose of this section, ''comments'' shall mean the major points raised in testimony which specifically address the regulatory criteria upon which the department is authorized, pursuant to subdivision (e) of Section 14105.4, to base a decision to add or delete a drug from the formulary.

(B) The recommendation of the Medical Therapeutic and Drug Advisory Committee.

(C) The decision of the department.

(D) A statement of the reason and the specific regulatory criteria that are the basis of the department's decision.

(b) Any additional information provided to the department during the posting of revisions to the proposed regulation shall be responded to by the department directly and in writing to the originator. That response shall notify the originator whether the additional information has resulted in a changed decision.

(c) For the purpose of review by the court, if any, and review and approval by the Office of Administrative Law of changes to the Medi-Cal drug formulary adopted by the department, each drug added to, or deleted from, the formulary shall be considered to be a separate regulation and shall be severable from all other additions or deletions of drugs contained in the rulemaking file.

(d) This section shall be applicable to any Medi-Cal drug formulary regulation package filed with the Office of Administrative Law on or after January 1, ~~1997~~ *1999*.

(e) This section shall become operative on January 1, ~~1997~~ *1999*.

SEC. 40. Section 14105.42 of the Welfare and Institutions Code, as amended by Chapter 716 of the Statutes of 1992, is amended to read:

14105.42. (a) The department shall report to the Legislature after the first three major therapeutic categories have been reviewed and contracts executed. The report shall include the estimated savings, number of manufacturers entering negotiations, number of contracts executed, number of drugs added and deleted, and impact on Medi-Cal beneficiaries and providers.

(b) The department shall provide the following data to the Legislature and to the Auditor General by January 1, 1991, and every six months thereafter:

(1) The number of drug treatment authorization requests (TAR) received by facsimile, by secondary answering system and in person for each therapeutic category.

(2) The number of drug TARS requested, approved, denied, and returned.

(3) The length of time between the TAR request and the decision, specified by type of communication such as telephone or facsimile if available.

(4) For denied TARS, the number of fair hearings requested, approved, denied and pending.

(5) The numbers of providers who were unable to submit a request or made multiple attempts because of faulty or unavailable lines of communication, if available.

(6) The numbers of complaints made by beneficiaries and providers relating to difficulty or inability to obtain a TAR response.

(7) The status of the enhancements to the TAR process specified in Section 21 of Chapter 457 of the Statutes of 1990.

(8) The number of calls on the TAR line which are not getting through.

(c) The Auditor General shall prepare a report by February 1, 1991, and every 6 months thereafter providing a summary and analysis of the data specified in subdivision (b), and a comparative analysis of changes in the TAR process using June 1, 1990, as a base. The analysis

shall include a measure of increased or decreased ability to contact the department and receive a response in a shorter or greater period of time.

(d) *The Bureau of State Audits shall prepare a report by January 1, 1998, on the drug program management techniques of the drug contracting program, and the comparability of the program to other private sector third party payers. In completing its report the bureau may consult with the department, prescribing physicians, pharmacists, drug manufacturers, representatives of beneficiaries, and others as the bureau sees fit.*

(e) The department shall report to the Legislature, through the annual budget process, on the cost-effectiveness of contracts executed pursuant to Section 14105.33.

~~(e)~~

(f) This section shall remain in effect only until January 1, 1999, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 1999, deletes or extends that date.

SEC. 41. Section 14105.91 of the Welfare and Institutions Code is amended to read:

14105.91. The department may add a drug to the formulary which is a different dosage form, or strength of a drug product which is listed in the formulary without review by the Medical Therapeutics and Drug Advisory Committee and the addition shall be deemed to comply with the requirements of the California Administrative Procedures Act.

This section shall become operative on January 1, ~~1997~~ *1999*.

SEC. 42. Section 14105.915 of the Welfare and Institutions Code is amended to read:

14105.915. The department may remove any drug from the formulary at the expiration of the contract term or when the contract between the department and the manufacturer of that drug is terminated.

This section shall become operative on January 1, ~~1997~~ *1999*.

SEC. 43. Section 14105.916 of the Welfare and Institutions Code is amended to read:

14105.916. Notwithstanding any other provision of law, on and after January 1, ~~1997~~ *1999*, drugs on the Medi-Cal list of contract drugs shall become the Medi-Cal drug formulary.

SEC. 43.5. Section 14132.44 of the Welfare and Institutions Code is amended to read:

14132.44. (a) Targeted case management (TCM), pursuant to Section 1915(g) of the Social Security Act as amended by Public Law 99-272 (42 U.S.C. Sec. 1396n(g)), shall be covered as a benefit, effective January 1, 1995. Nothing in this section shall be construed to require any local governmental agency to implement TCM.

(b) A TCM provider furnishing TCM services shall be a local governmental agency under contract with the department to provide TCM services. Local educational agencies shall not be providers of case management services under this section.

(c) A TCM provider may contract with a nongovernmental entity or the University of California, or both, to provide TCM services on its behalf under the conditions specified by the department in regulations.

(d) Each TCM provider shall have all of the following:

(1) Established procedures for performance monitoring.

(2) A countywide system to prevent duplication of services and to ensure coordination and continuity of care among providers of case management services provided to beneficiaries who are eligible to receive case management services from two or more programs.

(3) A fee mechanism effective January 1, 1995, specific to TCM services provided, which may vary by program.

(e) A TCM service provider, a nongovernmental entity or the University of California, or both, under contract with a TCM provider may provide TCM services to one or all of the following groups of Medi-Cal beneficiaries, which shall be defined in regulation:

(1) High-risk persons.

(2) Persons who have language or other comprehension barriers.

(3) Persons on probation.

(4) Persons who have exhibited an inability to handle personal, medical, or other affairs.

(5) Persons abusing alcohol or drugs, or both.

(6) Adults at risk of institutionalization.

(7) Adults at risk of abuse or neglect.

(f) (1) A local governmental agency that elects to provide TCM services to the groups specified in subdivision (e) shall, for each fiscal year, for the purpose of obtaining federal medicaid matching funds, submit an annual cost report as prescribed by the department that certifies all of the following:

(A) The availability and expenditure of 100 percent of the nonfederal share for the provision of TCM services from the local governmental agency's general fund or from any other funds allowed under federal law and regulation.

(B) The amount of funds expended on allowable TCM services.

(C) Its expenditures represent costs that are eligible for federal financial participation.

(D) The costs reflected in the annual cost reports used to determine TCM rates are developed in compliance with the definitions contained in the Office of Management and Budget (OMB) Circular A-87.

(E) Case management services provided in accordance with Section 1396n(g) of Title 42 of the United States Code will not duplicate case management services provided under any home- and community-based services waiver.

(F) Claims for providing case management services pursuant to this section will not duplicate claims made to public agencies or private entities under other program authorities for the same purposes.

(G) The requirements of subdivision (d) have been met.

(2) The department shall deny any claim if it determines that any certification required by this

subdivision is not adequately supported for purposes of federal financial participation.

(g) Only a local governmental agency may submit TCM service claims to the department for the performance of TCM services.

(h) During the period from January 1, 1995, through June 30, 1995, TCM services shall be reimbursed according to the interim mechanism developed by the state and the Health Care Financing Administration, which is reflected in the document entitled ''Agreement Between the Health Care Financing Administration and the State of California, Department of Health Services.'' For the 1995–96 fiscal year, the department shall establish an initial rate of reimbursement. Effective July 1, 1996, and thereafter, TCM services shall be reimbursed in accordance with regulations that shall be adopted by the department.

(i) The department, in consultation with local governmental agencies, and consistent with federal regulations, and the State Medicaid Manual of the Department of Health and Human Services, Health Care Financing Administration, shall adopt regulations that define TCM services, establish the standards under which TCM services qualify as a Medi-Cal reimbursable service, prescribe the methodology for determining the rate of reimbursement, and establish a claims submission and processing system and method to certify local matching expenditures.

(j) (1) Notwithstanding any other provision of this section, the state shall be held harmless, in accordance with paragraphs (2) and (3) from any federal audit disallowance and interest resulting from payments made by the federal medicaid program as reimbursement for claims for providing TCM services pursuant to this section, less the amounts already remitted to the state pursuant to subdivision (m) for the disallowed claim.

(2) To the extent that a federal audit disallowance and interest results from a claim or claims for which any local governmental agency has received reimbursement for TCM services, the department shall recoup from the local

governmental agency that submitted that disallowed claim, through offsets or by a direct billing, amounts equal to the amount of the disallowance and interest, in that fiscal year, less the amounts already remitted to the state pursuant to subdivision (m) for the disallowed claim. All subsequent claims submitted to the department applicable to any previously disallowed claim, may be held in abeyance, with no payment made, until the federal disallowance issue is resolved.

(3) Notwithstanding paragraphs (1) and (2), to the extent that a federal audit disallowance and interest results from a claim or claims for which the local governmental agency has received reimbursement for TCM services performed by a nongovernmental entity or the University of California, or both, under contract with, and on behalf of, the participating local governmental agency, the department shall be held harmless by that particular local governmental agency for 100 percent of the amount of any such federal audit disallowance and interest, less the amounts already remitted to the state pursuant to subdivision (m) for the disallowed claim.

(k) The use of local matching funds required by this section shall not create, lead to, or expand the health care funding obligations or service obligations for current or future years for each local governmental agency, except as required by this section or as may be required by federal law.

(*l*) TCM services are services which assist beneficiaries to gain access to needed medical, social, educational, and other services. Services provided by TCM providers, and their subcontractors, shall be defined in regulation, and shall include at least one of the following:

(1) Assessment.

(2) Plan development.

(3) Linkage and consultation.

(4) Assistance in accessing services.

(5) Periodic review.

(6) Crisis assistance planning.

(m) (1) Each local government agency shall contribute to the department a portion of the agency's general fund that has been made available due to the coverage of services described in this section under the Medi-Cal program. ~~For both the 1994–95 and 1995–96 fiscal years, this contribution shall not exceed twenty million dollars ($20,000,000) in each fiscal year less the amount contributed pursuant to subdivision (m) of Section 14132.47.~~ The contributed funds shall be reinvested in health services through the Medi-Cal program. The total contribution amount shall be equal to $33^1/_3$ percent of the amounts that have been made available under this section, *but in no case shall this contribution exceed twenty million dollars ($20,000,000) in a fiscal year less the amount contributed pursuant to subdivision (m) of Section 14132.47*. Beginning with the 1994–95 fiscal year, each local governmental agency's share of the total contribution shall be determined by claims submitted and approved for payment through January 1 of the following calendar year. Claims received and approved for payment after January 1 for dates of service in the previous fiscal year shall be included in the following year's calculation. Each local governmental agency's share of the contribution for the previous fiscal year shall be determined no later than February 15 and shall be remitted to the state no later than April 1 of each year. The contribution amount shall be paid from nonfederal, general fund revenues, and shall be deposited in the Targeted Case Management Claiming Fund, which is hereby created, for transfer to the Health Care Deposit Fund.

(2) Moneys received by the department pursuant to this subdivision are hereby continuously appropriated, notwithstanding Section 13340 of the Government Code, to the department for the support of the Medi-Cal program, and the funds shall be administered in accordance with procedures prescribed by the Department of Finance. If not paid as provided in this section, the department may offset payments due to each local governmental agency from the state, not related to

payments required to be made pursuant to this section, in order to recoup these funds for the Targeted Case Management Claiming Fund.

(n) As a condition of participation and in consideration of the joint effort of the local governmental agencies and the department in implementing this section and the ongoing need of local governmental agencies to receive technical support from the department, as well as assistance in claims processing and program monitoring, the local governmental agencies shall cover the costs of the administrative activities performed by the department. Each local governmental agency shall annually pay a portion of the total costs of administrative activities performed by the department through a mechanism agreed to by the department and the local governmental agencies, or if no agreement is reached by August 1 of each year, directly to the state. The department shall determine and report the staffing requirements upon which projected costs will be based. Projected costs shall include the anticipated salaries, benefits, and operating expenses necessary to administer targeted case management.

(o) For the purposes of this section a ‘‘local governmental agency’’ means a county or chartered city.

SEC. 44. Section 14132.47 of the Welfare and Institutions Code is amended to read:

14132.47. (a) It is the intent of the Legislature to provide local governmental agencies the choice of participating in either or both of the Targeted Case Management (TCM) and Administrative Claiming process programs at their option, subject to the requirements of this section and Section 14132.44.

(b) The department may contract with each participating local governmental agency to assist with the performance of administrative activities necessary for the proper and efficient administration of the Medi-Cal program, pursuant to Section 1396b(a) of Title 42 of the United States Code, Section 1903a of the federal Social Security Act, and this activity shall be known as the Administrative Claiming process.

(c) (1) As a condition for participation in the Administrative Claiming process, each participating local governmental agency shall, for the purpose of claiming federal medicaid matching funds, enter into a contract with the department and shall certify to the department the amount of local governmental agency general funds or any other funds allowed under federal law and regulation expended on the allowable administrative activities.

(2) The department shall deny the claim if it determines that the certification is not adequately supported for purposes of federal financial participation.

(d) Each participating local governmental agency may subcontract with nongovernmental entities to assist with the performance of administrative activities necessary for the proper and efficient administration of the Medi-Cal program under the conditions specified by the department in regulations. A nongovernmental entity may include a local educational agency.

(e) Each Administrative Claiming process contract shall include a requirement that each participating local governmental agency submit a claiming plan in a manner that shall be prescribed by the department in regulations, developed in consultation with local governmental agencies.

(f) The department shall require that each participating local governmental agency certify to the department both of the following:

(1) The availability and expenditure of 100 percent of the nonfederal share of the cost of performing Administrative Claiming process activities. The funds expended for this purpose shall be from the local governmental agency's general fund or from any other funds allowed under federal law and regulation.

(2) In each fiscal year that its expenditures represent costs that are eligible for federal financial participation for that fiscal year. The department shall deny the claim if it determines that the certification is not adequately supported for purposes of federal financial participation.

(g) (1) Notwithstanding any other provision of this section, the state shall be held harmless, in accordance with paragraphs (2) and (3), from any federal audit disallowance and interest resulting from payments made to a participating local governmental agency pursuant to this section, less the amounts already remitted to the state pursuant to subdivision (m) for the disallowed claim.

(2) To the extent that a federal audit disallowance and interest results from a claim or claims for which any participating local governmental agency has received reimbursement for Administrative Claiming process activities, the department shall recoup from the local governmental agency that submitted the disallowed claim, through offsets or by a direct billing, amounts equal to the amount of the disallowance and interest, in that fiscal year, less the amounts already remitted to the state pursuant to subdivision (m) for the disallowed claim. All subsequent claims submitted to the department applicable to any previously disallowed administrative activity or claim, may be held in abeyance, with no payment made, until the federal disallowance issue is resolved.

(3) Notwithstanding paragraph (2), to the extent that a federal audit disallowance and interest results from a claim or claims for which the participating local governmental agency has received reimbursement for Administrative Claiming process activities performed by a nongovernmental entity under contract with, and on behalf of, the participating local governmental agency, the department shall be held harmless by that particular participating local governmental agency for 100 percent of the amount of any such federal audit disallowance and interest, less the amounts already remitted to the state pursuant to subdivision (m) for the disallowed claim.

(h) The use of local matching funds required by this section shall not create, lead to, or expand the health care funding obligations or service obligations for current or future years for any participating local governmental agency, except as required by this section or as may be required by federal law.

(i) The department shall deny any claim from a participating local governmental agency if the department determines that the claim is not adequately supported in accordance with criteria established pursuant to this subdivision and implementing regulations before it forwards such a claim for reimbursement to the federal medicaid program. In consultation with local government agencies, the department shall adopt regulations that prescribe the requirements for the submission and payment of claims for administrative activities performed by each participating local agency.

(j) Administrative activities shall be those determined by the department to be necessary for the proper and efficient administration of the state's medicaid plan and shall be defined in regulation.

(k) If the department denies any claim submitted under this section, the affected participating local governmental agency may, within 30 days after receipt of written notice of the denial, request that the department reconsider its action. The participating local governmental agency may request a meeting with the director or his or her designee within 30 days to present its concerns to the department after the request is filed. If the director or his or her designee cannot meet, the department shall respond in writing indicating the specific reasons for which the claim is out of compliance to the participating local governmental agency in response to its appeal. Thereafter, the decision of the director shall be final.

(*l*) Participating local governmental agencies may claim the actual costs of nonemergency, nonmedical transportation of Medi-Cal eligibles to Medi-Cal covered services, under guidelines established by the department, to the extent that these costs are actually borne by the participating local governmental agency.

(m) (1) Each participating local governmental agency shall contribute to the department a portion of the agency's general fund that has been made available due to the coverage of administrative activities described

in this section under the Medi-Cal program. ~~For both the 1994-95 and 1995-96 fiscal years, this contribution shall not exceed twenty million dollars ($20,000,000) each fiscal year less the amount contributed pursuant to subdivision (m) of Section 14132.44.~~ The contributed funds shall be reinvested in health services through the Medi-Cal program. The total contribution amount shall be equal to $33\ 1/3$ percent of amounts made available under this section, *but in no case shall the contribution exceed twenty million dollars ($20,000,000) a fiscal year less the amount contributed pursuant to subdivision (m) of Section 14132.44*. Beginning with the 1994–95 fiscal year, each local governmental agency's share of the total contribution shall be determined by claims submitted and approved for payment through January 1 of the following calendar year. Claims received and approved for payment after January 1 for dates of service in the previous fiscal year shall be included in the following year's calculation. Each local governmental agency's share of the contribution for the previous fiscal year shall be determined no later than February 15 and shall be remitted to the state no later than April 1 of each year. The contribution amount shall be paid from nonfederal, general fund revenues and shall be deposited in the Administrative Claiming Fund for transfer to the Health Care Deposit Fund.

(2) Moneys received by the department pursuant to this subdivision are hereby continuously appropriated to the department for support of the Medi-Cal program, and the funds shall be administered in accordance with procedures prescribed by the Department of Finance. If not paid as provided in this section, the department may offset payments due to each participating local governmental agency from the state, not related to payments required to be made pursuant to this section in order to recoup these funds for the Administrative Claiming Fund.

(n) As a condition of participation in the Administrative Claiming process and in recognition of revenue generated to each participating local

governmental agency in the Administrative Claiming process, each participating local governmental agency shall pay an annual participation fee through a mechanism agreed to by the state and local governmental agencies, or, if no agreement is reached by August 1 of each year, directly to the state. The participation fee shall be used to cover the cost of administering the Administrative Claiming process, including, but not limited to, claims processing, technical assistance, and monitoring. The department shall determine and report staffing requirements upon which projected costs will be based. The amount of the participation fee shall be based upon the anticipated salaries, benefits, and operating expenses, to administer the Administrative Claiming process and other costs related to that process.

(o) For the purposes of this section ''participating local governmental agency'' means a county or chartered city under contract with the department pursuant to subdivision (b).

(p) For the purposes of this section, a ''nongovernmental entity'' does not include an entity or person administered by, affiliated with, or employed by a participating local governmental agency.

(q) The requirements of subdivision (m) shall not apply to claims for administrative activities, pursuant to the Administrative Claiming process, performed by public health programs administered by the state.

(r) A participating local governmental agency may charge an administrative fee to any entity claiming Administrative Claiming through that agency.

(s) The department shall continue to administer the Administrative Claiming process in conformity with federal requirements.

(t) The department shall provide technical assistance to all participating local governmental agencies in order to maximize federal financial participation in the Administrative Claiming process.

(u) This section shall be applicable to Administrative Claiming process activities performed, and to moneys

paid to participating local governmental agencies for those activities, in the 1994–95 fiscal year and thereafter.

SEC. 45. Section 14132.90 of the Welfare and Institutions Code is amended to read:

14132.90. (a) As of September 15, 1995, day care habilitative services, pursuant to subdivision (c) of Section 14021 shall be provided only to alcohol and drug exposed pregnant women and women in the postpartum period, or as required by federal law.

(b) (1) Notwithstanding any other provision of law, except to the extent required by federal law, *if, as of May 15, 1997, the projected costs for the 1996–97 fiscal year for* outpatient drug abuse services, as described in Section 14021, ~~shall not be benefits under this chapter as of July 1, 1996, if the projected costs for those outpatient drug abuse services for the 1995–96 fiscal year as of May 15, 1996,~~ exceed ~~sixty million dollars ($60,000,000)~~ *forty-five million dollars ($45,000,000)* in state General Fund moneys, *then the outpatient drug free services, as defined in Section 51341.1 of Title 22 of the California Code of Regulations, shall not be a benefit under this chapter as of July 1, 1997*.

(2) Notwithstanding paragraph (1), outpatient methadone maintenance and Naltrexone shall remain benefits under this chapter.

(3) Notwithstanding paragraph (1), residential care, outpatient drug free services, and day care habilitative services, for alcohol and drug exposed pregnant women and women in the postpartum period shall remain benefits under this chapter.

SEC. 46. Section 14133.22 of the Welfare and Institutions Code is amended to read:

14133.22. (a) Prescribed drugs shall be limited to no more than six per month, unless prior authorization is obtained.

(b) The limit in subdivision (a) shall not apply to patients receiving care in a nursing facility.

(c) The limit in subdivision (a) shall not apply to drugs for family planning.

(d) The department may issue Medi-Cal cards that contain labels for prescribed drugs to implement this section.

(e) In carrying out this section, the department may contract either directly, or through the fiscal intermediary, for pharmacy consultant staff necessary to accomplish the treatment authorization request reviews. ~~This authority shall extend for a maximum of 36 months from the date of the initial contract.~~

SEC. 47. Section 14148.5 of the Welfare and Institutions Code is amended to read:

14148.5. (a) State funded perinatal services shall be provided under the Medi-Cal program to pregnant women and state funded medical services to infants up to one year of age in families with incomes above 185 percent, but not more than 200 percent of the federal poverty level, in the same manner that these services are being provided to the Medi-Cal population, including eligibility requirements and integration of eligibility determinations and payment of claims, except as follows:

(1) The assets of the family shall not be considered in making the eligibility determination.

(2) The income deduction specified in subdivision (f) of Section 14148 shall not be applied.

(b) Services provided under this section shall not be subject to any share-of-cost requirements.

(c) (1) The department, in implementing the Medi-Cal program and public health programs, in coordination with the Major Risk Medical Insurance Programs Access for Infants and Mothers component shall provide for outreach activities in order to enhance participation and access to perinatal services. ~~Notwithstanding Section 30122 of the Revenue and Taxation Code, funding for these outreach activities shall be made available from the funds appropriated for purposes of this section, and to the extent permissible, from funding received pursuant to Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.~~ Funding received pursuant to

the federal provisions shall be used to expand perinatal outreach activities.

(2) Those outreach activities required by paragraph (1) shall be targeted toward both Medi-Cal and non-Medi-Cal eligible high risk or uninsured pregnant women and infants. Outreach activities may include, but not be limited to, all of the following:

(A) Education of the targeted women on the availability and importance of early prenatal care and referral to Medi-Cal and other programs.

(B) Information provided through toll-free telephone numbers.

(C) Recruitment and retention of perinatal providers.

(d) ~~The amendment made to paragraph (1) of subdivision (c) by Senate Bill 99 of the 1991-92 Regular Session constitutes an amendment to the Tobacco Tax and Health Protection Act of 1988.~~

~~(e) This section shall remain operative only until July 1, 1996, and shall remain in effect only until January 1, 1997, and as of that date is repealed, unless a later enacted statute, which is effective on or before January 1, 1997, deletes or extends that date.~~ *Notwithstanding any other provision of law, contracts required to implement the provisions of this section shall be exempt from the approval of the Director of General Services and from the provisions of the Public Contract Code.*

(e) The programs authorized in this section shall be operative for the entire 1996–97 fiscal year.

SEC. 48. Section 14163 of the Welfare and Institutions Code is amended to read:

14163. (a) For purposes of this section, the following definitions shall apply:

(1) ''Public entity'' means a county, a city, a city and county, the University of California, a local hospital district, a local health authority, or any other political subdivision of the state.

(2) ''Hospital'' means a health facility that is licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code to provide

acute inpatient hospital services, and includes all components of the facility.

(3) ‘‘Disproportionate share hospital’’ means a hospital providing acute inpatient services to Medi-Cal beneficiaries that meets the criteria for disproportionate share status relating to acute inpatient services set forth in Section 14105.98.

(4) ‘‘Disproportionate share list’’ means the annual list of disproportionate share hospitals for acute inpatient services issued by the department pursuant to Section 14105.98.

(5) ‘‘Fund’’ means the Medi-Cal Inpatient Payment Adjustment Fund.

(6) ‘‘Eligible hospital’’ means, for a particular state fiscal year, a hospital on the disproportionate share list that is eligible to receive payment adjustment amounts under Section 14105.98 with respect to that state fiscal year.

(7) ‘‘Transfer year’’ means the particular state fiscal year during which, or with respect to which, public entities are required by this section to make an intergovernmental transfer of funds to the Controller.

(8) ‘‘Transferor entity’’ means a public entity that, with respect to a particular transfer year, is required by this section to make an intergovernmental transfer of funds to the Controller.

(9) ‘‘Transfer amount’’ means an amount of intergovernmental transfer of funds that this section requires for a particular transferor entity with respect to a particular transfer year.

(10) ‘‘Intergovernmental transfer’’ means a transfer of funds from a public entity to the state, that is local government financial participation in Medi-Cal pursuant to the terms of this section.

(11) ‘‘Licensee’’ means an entity that has been issued a license to operate a hospital by the department.

(12) ‘‘Annualized Medi-Cal inpatient paid days’’ means the total number of Medi-Cal acute inpatient hospital days, regardless of dates of service, for which payment was made by or on behalf of the department to

a hospital, under present or previous ownership, during the most recent calendar year ending prior to the beginning of a particular transfer year, including all Medi-Cal acute inpatient covered days of care for hospitals that are paid on a different basis than per diem payments.

(13) ''Medi-Cal acute inpatient hospital day'' means any acute inpatient day of service attributable to patients who, for those days, were eligible for medical assistance under the California state plan, including any day of service that is reimbursed on a basis other than per diem payments.

(b) The Medi-Cal Inpatient Payment Adjustment Fund is hereby created in the State Treasury. Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to, and under the administrative control of, the department for the purposes specified in subdivision (d). The fund shall consist of the following:

(1) Transfer amounts collected by the Controller under this section, whether submitted by transferor entities pursuant to subdivision (i) or obtained by offset pursuant to subdivision (j).

(2) Any other intergovernmental transfers deposited in the fund, as permitted by Section 14164.

(3) Any interest that accrues with respect to amounts in the fund.

(c) Moneys in the fund, which shall not consist of any state general funds, shall be used as the source for the nonfederal share of payments to hospitals pursuant to Section 14105.98. Moneys shall be allocated from the fund by the department and matched by federal funds in accordance with customary Medi-Cal accounting procedures, and used to make payments pursuant to Section 14105.98.

(d) Except as otherwise provided in Section 14105.98 or in any provision of law appropriating a specified sum of money to the department for administering this section and Section 14105.98, moneys in the fund shall be used only for the following:

(1) Payments to hospitals pursuant to Section 14105.98.

(2) Except for the amount transferred pursuant to paragraph (3), transfers to the Health Care Deposit Fund ~~in~~ *as follows:*

(A) In the amount of two hundred thirty-nine million seven hundred fifty-seven thousand six hundred ninety dollars ($239,757,690), for the 1994–95 ~~fiscal year and for each fiscal year thereafter~~ *and 1995–96 fiscal years*.

(B) In the amount of two hundred twenty-nine million seven hundred fifty-seven thousand six hundred ninety dollars ($229,757,690) for the 1996–97 fiscal year and each fiscal year thereafter.

(C) Notwithstanding any other provision of law, the amount specified in this paragraph shall be in addition to any amounts transferred to the Health Care Deposit Fund arising from changes of any kind attributable to payment adjustment years prior to the 1993–94 payment adjustment year. These transfers from the fund shall be made in six equal monthly installments to the Medi-Cal local assistance appropriation item (Item 4260-101-001 of the annual Budget Act) in support of Medi-Cal expenditures. The first installment shall accrue in October of each transfer year, and all other installments shall accrue monthly thereafter from November through March.

(3) In the 1993–94 fiscal year, in addition to the amount transferred as specified in paragraph (2), fifteen million dollars ($15,000,000) shall also be transferred to the Medi-Cal local assistance appropriation item (Item 4260-101-001) of the Budget Act of 1993.

(e) For the 1991–92 state fiscal year, the department shall determine, no later than 70 days after the enactment of this section, the transferor entities for the 1991–92 transfer year. To make this determination, the department shall utilize the disproportionate share list for the 1991–92 fiscal year, which shall be issued by the department no later than 65 days after the enactment of this section, pursuant to paragraph (1) of subdivision (f) of Section 14105.98. The department shall identify each eligible hospital on the list for which a public entity is the

licensee as of July 1, 1991. The public entity that is the licensee of each identified eligible hospital shall be a transferor entity for the 1991–92 transfer year.

(f) The department shall determine, no later than 70 days after the enactment of this section, the transfer amounts for the 1991–92 transfer year.

The transfer amounts shall be determined as follows:

(1) The eligible hospitals for 1991–92 shall be identified. For each hospital, the applicable total per diem payment adjustment amount under Section 14105.98 for the 1991–92 transfer year shall be computed. This amount shall be multiplied by 80 percent of the eligible hospital's annualized Medi-Cal inpatient paid days as determined from all Medi-Cal paid claims records available through April 1, 1991. The products of these calculations for all eligible hospitals shall be added together to determine an aggregate sum for the 1991–92 transfer year.

(2) The eligible hospitals for 1991–92 involving transferor entities as licensees shall be identified. For each hospital, the applicable total per diem payment adjustment amount under Section 14105.98 for the 1991–92 transfer year shall be computed. This amount shall be multiplied by 80 percent of the eligible hospital's annualized Medi-Cal inpatient paid days as determined from all Medi-Cal paid claims records available through April 1, 1991. The products of these calculations for all eligible hospitals with transferor entities as licensees shall be added together to determine an aggregate sum for the 1991–92 transfer year.

(3) The aggregate sum determined under paragraph (1) shall be divided by the aggregate sum determined under paragraph (2), yielding a factor to be utilized in paragraph (4).

(4) The factor determined in paragraph (3) shall be multiplied by the amount determined for each hospital under paragraph (2). The product of this calculation for each hospital in paragraph (2) shall be divided by 1.771, yielding a transfer amount for the particular transferor

entity for the transfer year, except as provided by paragraph (5).

(5) Only for the transfer year with respect to which the payment adjustment program set forth in Section 14105.98 first gains federal approval, a reduction in the transfer amount determined pursuant to paragraph (4) shall be applicable under the following circumstances:

(A) To determine any such reduction, the transfer amount determined pursuant to paragraph (4) shall first be multiplied by a fraction, the numerator of which is the number of days of the transfer year for which federal approval is effective and the denominator of which is 365.

(B) If the product of the calculation under subparagraph (A) is 80 percent or more of the transfer amount determined under paragraph (4), no reduction of the transfer amount determined under paragraph (4) shall apply.

(C) If the product of the calculation under subparagraph (A) is less than 80 percent of the transfer amount determined under paragraph (4), a reduction shall apply to the transfer amount determined under paragraph (4). The reduction shall be that particular amount which is equal to the difference between (i) the transfer amount determined under paragraph (4) and (ii) the amount calculated under subparagraph (A) divided by 80 percent.

(D) Any reduction of a transfer amount applicable under subparagraph (C) shall be spread equally among the installments referred to in subdivision (i).

(g) For the 1991–92 transfer year, the department shall notify each transferor entity in writing of its applicable transfer amount or amounts no later than 70 days after the enactment of this section, which amount or amounts shall be subject to adjustment pursuant to subdivisions (f) and (i).

(h) For the 1992–93 transfer year and subsequent transfer years, transfer amounts shall be determined in the same procedural manner as set forth in subdivision (f), except:

(1) The department shall use all of the following:

(A) The disproportionate share list applicable to the particular transfer year to determine the eligible hospitals.

(B) The payment adjustment amounts calculated under Section 14105.98 for the particular transfer year. These amounts shall take into account any projected or actual increases or decreases in the size of the payment adjustment program as are required under Section 14105.98 for the particular year in question. Subject to the installment schedule in paragraph (5) of subdivision (i) regarding transfer amounts, the department may issue interim, revised, and supplemental transfer requests as necessary and appropriate to address changes in payment adjustment levels that occur under Section 14105.98. All transfer requests, or adjustments thereto, issued to transferor entities by the department shall meet the requirements set forth in subparagraph (E) of paragraph (5) of subdivision (i).

(C) Data regarding annualized Medi-Cal inpatient paid days for the most recent calendar year ending prior to the beginning of the particular transfer year, as determined from all Medi-Cal paid claims records available through April 1 preceding the particular transfer year.

(D) The status of public entities as licensees of eligible hospitals as of July 1 of the particular transfer year.

(E) The transfer amounts calculated by the department may be increased or decreased by a percentage amount consistent with the Medi-Cal State Plan.

(2) For the 1993–94 transfer year and subsequent transfer years, transfer amounts shall be increased on a pro rata basis for each transferor entity for the particular transfer year in the amounts necessary to fund the nonfederal share of the total supplemental lump-sum payment adjustment amounts that arise under Section 14105.98. For purposes of this paragraph, the supplemental lump-sum payment adjustment amounts shall be deemed to arise for the particular transfer year as of the date specified in Section 14105.98. Transfer

amounts to fund the nonfederal share of the payments shall be paid by the transferor entities for the particular transfer year within 20 days after the department notifies the transferor entity in writing of the additional transfer amount to be paid.

(3) The department shall prepare preliminary analyses and calculations regarding potential transfer amounts, and potential transferor entities shall be notified by the department of estimated transfer amounts as soon as reasonably feasible regarding any particular transfer year. Written notices of transfer amounts shall be issued by the department as soon as possible with respect to each transfer year. All state agencies shall take all necessary steps in order to supply applicable data to the department to accomplish these tasks. The Office of Statewide Health Planning and Development shall provide to the department quarterly access to the edited and unedited confidential patient discharge data files for all Medi-Cal eligible patients. The department shall maintain the confidentiality of that data to the same extent as is required of the Office of Statewide Health Planning and Development. In addition, the Office of Statewide Health Planning and Development shall provide to the department, not later than March 1 of each year, the data specified by the department, as the data existed on the statewide data base file as of February 1 of each year, from all of the following:

(A) Hospital annual disclosure reports, filed with the Office of Statewide Health Planning and Development pursuant to Section 443.31 of the Health and Safety Code, for hospital fiscal years that ended during the calendar year ending 13 months prior to the applicable February 1.

(B) Annual reports of hospitals, filed with the Office of Statewide Health Planning and Development pursuant to Section 439.2 of the Health and Safety Code, for the calendar year ending 13 months prior to the applicable February 1.

(C) Hospital patient discharge data reports, filed with the Office of Statewide Health Planning and

Development pursuant to subdivision (g) of Section 443.31 of the Health and Safety Code, for the calendar year ending 13 months prior to the applicable February 1.

(D) Any other materials on file with the Office of Statewide Health Planning and Development.

(4) For the 1993–94 transfer year and subsequent transfer years, the divisor to be used for purposes of the calculation referred to in paragraph (4) of subdivision (f) shall be determined by the department. The divisor shall be calculated to ensure that the appropriate amount of transfers from transferor entities are received into the fund to satisfy the requirements of Section 14105.98 for the particular transfer year. For the 1993–94 transfer year, the divisor shall be 1.742.

(5) For the 1993–94 fiscal year, the transfer amount that would otherwise be required from the University of California shall be increased by fifteen million dollars ($15,000,000).

(6) Notwithstanding any other provision of law, the total amount of transfers required from the transferor entities for any particular transfer year shall not exceed the sum of the following:

(A) The amount needed to fund the nonfederal share of all payment adjustment amounts applicable to the particular payment adjustment year as calculated under Section 14105.98. Included in the calculations for this purpose shall be any decreases in the program as a whole, and for individual hospitals, that arise due to the provisions of Section 1396r-4(f) of Title 42 of the United States Code.

(B) The amount needed to fund the transfers to the Health Care Deposit Fund, as referred to in paragraphs (2) and (3) of subdivision (d).

(7) (A) Except as provided in subparagraph (B) and in subparagraph (A) of paragraph (2) of subdivision (j), and except for a prudent reserve not to exceed two million dollars ($2,000,000) in the Medi-Cal Inpatient Payment Adjustment Fund, any amounts in the fund, including interest that accrues with respect to the

amounts in the fund, that are not expended, or estimated to be required for expenditure, under Section 14105.98 with respect to a particular transfer year shall be returned on a pro rata basis to the transferor entities for the particular transfer year within 120 days after the department determines that the funds are not needed for an expenditure in connection with the particular transfer year.

(B) The department shall determine the interest amounts that have accrued in the fund from its inception through June 30, 1995, and, no later than January 1, 1996, shall distribute these interest amounts to transferor entities, as follows:

(i) The total amount transferred to the fund by each transferor entity for all transfer years from the inception of the fund through June 30, 1995, shall be determined.

(ii) The total amounts determined for all transferor entities under clause (i) shall be added together, yielding an aggregate of the total amounts transferred to the fund for all transfer years from the inception of the fund through June 30, 1995.

(iii) The total amount determined under clause (i) for each transferor entity shall be divided by the aggregate amount determined under clause (ii), yielding a percentage for each transferor entity.

(iv) The total amount of interest earned by the fund from its inception through June 30, 1995, shall be determined.

(v) The percentage determined under clause (iii) for each transferor entity shall be multiplied by the amount determined under clause (iv), yielding the amount of interest that shall be distributed under this subparagraph to each transferor entity.

(C) Regarding any funds returned to a transferor entity under subparagraph (A), or interest amounts distributed to a transferor entity under subparagraph (B), the department shall provide to the transferor entity a written statement that explains the basis for the particular return or distribution of funds and contains the general calculations used by the department in

determining the amount of the particular return or distribution of funds.

(i) (1) For the 1991–92 transfer year, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in eight equal installments. Except as provided below, the first installment shall accrue on July 25, 1991, and all other installments shall accrue on the 5th day of each month thereafter from August through February.

(2) Notwithstanding paragraph (1), no installment shall be payable to the Controller until that date which is 20 days after the department notifies the transferor entity in writing that the payment adjustment program set forth in Section 14105.98 has first gained federal approval as part of the Medi-Cal program. For purposes of this paragraph, federal approval requires both (i) approval by appropriate federal agencies of an amendment to the Medi-Cal State Plan, as referred to in subdivision (o) of Section 14105.98, and (ii) confirmation by appropriate federal agencies regarding the availability of federal financial participation for the payment adjustment program set forth in Section 14105.98 at a level of at least 40 percent of the percentage of federal financial participation that is normally applicable for Medi-Cal expenditures for acute inpatient hospital services.

(3) If any installment that would otherwise be payable under paragraph (1) is not paid because of the provisions of paragraph (2), then subparagraphs (A) and (B) shall be followed when federal approval is gained.

(A) All installments that were deferred based on the provisions of paragraph (2) shall be paid no later than 20 days after the department notifies the transferor entity in writing that federal approval has been gained, in an amount consistent with subparagraph (B).

(B) The installments paid pursuant to subparagraph (A) shall be paid in full, subject to an adjustment in amount pursuant to paragraph (5) of subdivision (f).

(4) All installments for the 1991–92 transfer year that arise in months after federal approval is gained shall be paid by the 5th day of the month or 20 days after the

department notifies the transferor entity in writing that federal approval has been gained, whichever is later. These installments shall be subject to an adjustment in amount pursuant to paragraph (5) of subdivision (f).

(5) (A) Except as provided in subparagraphs (B) and (C), for the 1992–93 transfer year and subsequent transfer years, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in eight equal installments. The first installment shall be payable on July 10 of each transfer year. All other installments shall be payable on the 5th day of each month thereafter from August through February.

(B) For the 1994–95 transfer year, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in five equal installments. The first installment shall be payable on October 5, 1994. The next four installments shall be payable on the fifth day of each month thereafter from November through February.

(C) For the 1995–96 transfer year, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in five equal installments. The first installment shall be payable on October 5, 1995. The next four installments shall be payable on the fifth day of each month thereafter from November through February.

(D) Except as otherwise specifically provided, subparagraphs (A) to (C), inclusive, shall not apply to increases in transfer amounts described in paragraph (2) of subdivision (h) or to additional transfer amounts described in subdivision (o).

(E) All requests for transfer payments, or adjustments thereto, issued by the department shall be in writing and shall include (i) an explanation of the basis for the particular transfer request or transfer activity, (ii) a summary description of program funding status for the particular transfer year, and (iii) the general calculations used by the department in connection with the particular transfer request or transfer activity.

(6) A transferor entity may use any of the following funds for purposes of meeting its transfer obligations under this section:

(A) General funds of the transferor entity.

(B) Any other funds permitted by law to be used for these purposes, except that a transferor entity shall not submit to the Controller any federal funds unless those federal funds are authorized by federal law to be used to match other federal funds. In addition, no private donated funds from any health care provider, or from any person or organization affiliated with such a health care provider, shall be channeled through a transferor entity or any other public entity to the fund. The transferor entity shall be responsible for determining that funds transferred meet the requirements of this subparagraph.

(j) (1) If a transferor entity does not submit any transfer amount within the time period specified in this section, the Controller shall offset immediately the amount owed against any funds which otherwise would be payable by the state to the transferor entity. The Controller, however, shall not impose an offset against any particular funds payable to the transferor entity where the offset would violate state or federal law.

(2) Where a withhold or a recoupment occurs pursuant to the provisions of paragraph (2) of subdivision (r) of Section 14105.98, the nonfederal portion of the amount in question shall remain in the fund, or shall be redeposited in the fund by the department, as applicable. The department shall then proceed as follows:

(A) If the withhold or recoupment was imposed with respect to a hospital whose licensee was a transferor entity for the particular state fiscal year to which the withhold or recoupment related, the nonfederal portion of the amount withheld or recouped shall serve as a credit for the particular transferor entity against an equal amount of transfer obligations under this section, to be applied whenever the transfer obligations next arise. Should no such transfer obligation arise within 180 days, the department shall return the funds in question to the particular transferor entity within 30 days thereafter.

(B) For other situations, the withheld or recouped nonfederal portion shall be subject to paragraph (7) of subdivision (h).

(k) All amounts received by the Controller pursuant to subdivision (i), paragraph (2) of subdivision (h), or subdivision (o), or offset by the Controller pursuant to subdivision (j), shall immediately be deposited in the fund.

(*l*) For purposes of this section, the disproportionate share list utilized by the department for a particular transfer year shall be identical to the disproportionate share list utilized by the department for the same state fiscal year for purposes of Section 14105.98. Nothing on a disproportionate share list, once issued by the department, shall be modified for any reason other than mathematical or typographical errors or omissions on the part of the department or the Office of Statewide Health Planning and Development in preparation of the list.

(m) Neither the intergovernmental transfers required by this section, nor any elective transfer made pursuant to Section 14164, shall create, lead to, or expand the health care funding or service obligations for current or future years for any transferor entity, except as required of the state by this section or as may be required by federal law, in which case the state shall be held harmless by the transferor entities on a pro rata basis.

(n) No amount submitted to the Controller pursuant to subdivision (i), paragraph (2) of subdivision (h), or subdivision (o), or offset by the Controller pursuant to subdivision (j), shall be claimed or recognized as an allowable element of cost in Medi-Cal cost reports submitted to the department.

(o) Whenever additional transfer amounts are required to fund the nonfederal share of payment adjustment amounts under Section 14105.98 that are distributed after the close of the particular payment adjustment year to which the payment adjustment amounts apply, the additional transfer amounts shall be paid by the parties who were the transferor entities for the particular transfer year that was concurrent with the

particular payment adjustment year. The additional transfer amounts shall be calculated under the formula that was in effect during the particular transfer year. For transfer years prior to the 1993–94 transfer year, the percentage of the additional transfer amounts available for transfer to the Health Care Deposit Fund under subdivision (d) shall be the percentage that was in effect during the particular transfer year. These additional transfer amounts shall be paid by transferor entities within 20 days after the department notifies the transferor entity in writing of the additional transfer amount to be paid.

(p) (1) Ten million dollars ($10,000,000) of the amount transferred from the Medi-Cal Inpatient Payment Adjustment Fund to the Health Care Deposit Fund due to amounts transferred attributable to years prior to the 1993–94 fiscal year is hereby appropriated without regard to fiscal years to the State Department of Health Services to be used to support the development of managed care programs under the department's plan to expand Medi-Cal managed care.

(2) These funds shall be used by the department for both of the following purposes: (A) distributions to counties or other local entities that contract with the department to receive those funds to offset a portion of the costs of forming the local initiative entity, and (B) distributions to local initiative entities that contract with the department to receive those funds to offset a portion of the costs of developing the local initiative health delivery system in accordance with the department's plan to expand Medi-Cal managed care.

(3) Entities contracting with the department for any portion of the ten million dollars ($10,000,000) shall meet the objectives of the department's plan to expand Medi-Cal managed care with regard to traditional and safety net providers.

(4) Entities contracting with the department for any portion of the ten million dollars ($10,000,000) may be authorized under those contracts to utilize their funds to provide for reimbursement of the costs of local

organizations and entities incurred in participating in the development and operation of a local initiative.

(5) To the full extent permitted by state and federal law, these funds shall be distributed by the department for expenditure at the local level in a manner that qualifies for federal financial participation under the medicaid program.

SEC. 49. Section 14511 is added to the Welfare and Institutions Code, to read:

14511. Notwithstanding any other provision of law, on and after the effective date of any repeal of Division 24 (commencing with Section 24000) of the Welfare and Institutions Code, the general statewide program for the provision of comprehensive clinical family planning services as referenced in this chapter shall be deemed to be operative in all respects, and the State Department of Health Services shall administer the program accordingly. It is the intent of the Legislature that appropriate funding be made available at that time for the general statewide program for the provision of comprehensive clinical family planning services as set forth in this chapter through the annual budget process.

SEC. 50. Section 14512 is added to the Welfare and Institutions Code, to read:

14512. It is the intent of the Legislature that all contracts for the provision of direct services entered into by the Office of Family Planning under this chapter shall be competitively awarded.

SEC. 51. Chapter 14 (commencing with Section 18993) is added to Part 6 of Division 9 of the Welfare and Institutions Code, to read:

CHAPTER 14. COMMUNITY CHALLENGE GRANT PROGRAM

18993. There is hereby created the Community Challenge Grant Program in the State Department of Health Services to provide community challenge grants to reduce the number of teenage and unwed pregnancies.

18993.1. The Legislature hereby finds and declares all of the following:

(a) One in three children in California is born out-of-wedlock.

(b) As many as 70,000 children were born to teenagers in each of at least the last two years and nearly 25 percent of these were born to teenage mothers who have previously had children.

(c) Children who grow up without fathers are five times more likely to be poor, twice as likely to drop out of school, and much more likely to end up in foster care or juvenile justice facilities.

(d) Girls raised in single-parent families are three times more likely to become unwed teenage mothers than those girls raised in two-parent families.

(e) Boys without a father in the home are more likely to become incarcerated, unemployed, or uninvolved with their own children when they become fathers.

(f) The consequences of teenage pregnancy and fatherlessness are significant and far-reaching.

(g) Teenage and unwed pregnancy are problems that affect community health and success.

(h) Government can best solve the problems of teenage and unwed pregnancies in partnership with local communities, parents, and families.

(i) Communities should decide what prevention strategies will work and be acceptable.

(j) Parents and families should be included in the teenage pregnancy prevention strategies.

18993.2. (a) The State Department of Health Services shall administer grants for purposes of this chapter that shall be awarded pursuant to a request for application process.

(b) Grants shall be awarded to existing and new community-based nonprofit organizations and county and local governments for purposes of implementing locally developed prevention and intervention strategies designed to do the following:

(1) Reduce the number of teenage and unwed pregnancies.

(2) Reduce the number of children growing up in homes without fathers as a result of these pregnancies.

(3) Promote responsible parenting and the involvement of the father in the economic, social, and emotional support of his children.

(c) Grant funding shall not be used for clinical services and shall target, but not be limited to, the following populations:

(1) Presexual adolescents.

(2) Sexually active adolescents.

(3) Pregnant and parenting adolescents.

(4) Parents and families.

(5) Adults at risk for unwed motherhood or absentee fatherhood.

(d) The department shall provide outreach and training to potential grantees to increase the number of agencies and groups that may be able to successfully compete for the grants.

(e) The department shall issue periodic reports that describe the projects that have been awarded grants pursuant to this chapter.

18993.3. (a) An advisory committee of 10 members shall be appointed to advise and consult with the department regarding the Community Challenge Grant Program in the following areas:

(1) The broad goals of the program.

(2) Effective strategies for implementing the program.

(3) Elements of evaluating the effectiveness of the program grantees.

(4) Strategies for engaging nongovernmental resources and expertise in the implementation and success of the program.

(b) Six members shall be appointed by the Secretary of the Health and Welfare Agency, two members by the Speaker of the Assembly, and two members by the Senate Committee on Rules.

(c) The advisory committee shall reflect a broad constituency and multidisciplinary approach to the problem of teenage and unwed pregnancy, including

persons that represent corporations and foundations, the religious community, parents, teenagers, the education and academic community, community-based organizations, and public health organizations.

18993.4. Grant applications shall include, but not be limited to, the following:

(a) Plans for community collaboration with parents, local agencies, businesses, school leaders, community groups, and private organizations.

(b) Measurable objectives selected by the applicant.

(c) Evidence of the applicant's capability to effect proposed changes.

(d) A needs assessment.

(e) A comprehensive description of the population or populations proposed to be served.

(f) A project description, a work plan, and budget justifications.

(g) A project evaluation and a process for data collection to facilitate the department's ability to conduct a statewide evaluation.

18993.5. (a) Criteria for grant selection shall include, but not be limited to, the following:

(1) Degree of community input and collaboration in the project.

(2) Degree of involvement of parents and families within the community.

(3) Degree of involvement of nongovernmental organizations.

(4) Degree of need for the project in the local community.

(5) Geographic, economic, population, and ethnic diversity.

(6) Feasibility.

(7) Cost effectiveness.

(8) Degree to which project outcomes can be measured and evaluated.

(b) The department shall provide an explanation for the reasons why an applicant is not funded.

18993.6. (a) Grantees shall be required to match a portion of the grant awarded under the Community

Challenge Grant Program with either dollar or measurable in-kind contributions as provided by this section.

(b) Grantees shall provide a match of not less than 10 percent for the first year of the grant, not less than 15 percent for the second year of the grant, and not less than 20 percent for the third year of the grant.

(c) The match required by this section shall be supplemental to the funds appropriated for the Community Challenge Grant Program and shall be from nongovernmental sources.

18993.7. (a) The costs for state administration of the Community Challenge Grant Program may be up to 5 percent of the total appropriation for the program. The Legislature shall be notified of the administrative costs of this program pursuant to Section 28 of the Budget Act of 1996. Indirect costs for grantees shall not exceed 10 percent of the grant amount.

(b) The department may use local assistance funds allocated for the program to provide training to potential grantees authorized by subdivision (d) of Section 18993.2.

(c) The department may use local assistance funds allocated to the program for the evaluation of the program required by subdivision (b) of Section 18993.8.

18993.8. The department shall conduct a statewide independent evaluation of the program. The department shall submit its findings from the evaluation to the Legislature on or before January 1, 1999.

18993.9. This chapter shall remain operative until July 1, 1999, and shall remain in effect only until January 1, 2000, and as of that date is repealed, unless a later enacted statute, which is effective on or before January 1, 2000, deletes or extends that date.

SEC. 52. Division 24 (commencing with Section 24000) is added to the Welfare and Institutions Code, to read:

DIVISION 24. STATE-ONLY FAMILY PLANNING PROGRAM

24000. There is established in the State Department of Health Services the State-Only Family Planning Program to provide comprehensive clinical family planning services to low-income men and women. This division shall be known and may be cited as the State-Only Family Planning Program.

24001. (a) For purposes of this division, "family planning" means the process of establishing objectives for the number and spacing of children, and selecting the means by which those objectives may be achieved. These means include a broad range of acceptable and effective methods and services to limit or enhance fertility, including contraceptive methods, natural family planning, abstinence methods and basic, limited fertility management. Family planning services include, but are not limited to, preconceptual counseling, maternal and fetal health counseling, general reproductive health care, including diagnosis and treatment of infections and conditions, including cancer, that threaten reproductive capability, medical family planning treatment and procedures, including supplies and followup, and informational, counseling, and educational services. Family planning does not include abortion, pregnancy testing solely for the purposes of referral for abortion or services ancillary to abortions, or pregnancy care that is not incident to the diagnosis of pregnancy.

(b) For purposes of this division, "department" means the State Department of Health Services.

24003. (a) A person shall be eligible to receive services pursuant to this chapter provided that the following conditions are met:

(1) The person is a resident of California.

(2) The person has a family income at or below 200 percent of the federal poverty level.

(3) The person has no other source of health care coverage unless the use of that health care coverage

would create a barrier to access because of confidentiality.

(4) The person is not otherwise eligible for existing Medi-Cal services without a share of cost.

(b) Notwithstanding any other provision of law, the provision of family planning services shall not require the consent of anyone other than the person who is to receive the services.

(c) Eligibility shall be determined at point of service by the provider. The provider shall obtain information on the individual's family size, income, and health care coverage and then, based on that information, determine if the individual meets the eligibility criteria specified in subdivision (a). All individuals who meet the eligibility requirements shall be certified by the provider as eligible for services under the program. A Medi-Cal share of cost shall not be used to deny access to family planning services under the program. The department may require the collection on a voluntary basis or the use of the individual's social security number, or both. No services shall be denied to a client if a social security number is not provided.

(d) Eligibility shall be based on the individual's self-declaration of gross annual or monthly income, family size, and other source of health care coverage, signed under penalty of perjury at each annual eligibility certification. No asset information shall be used to determine eligibility.

(e) The department may establish a copayment system for services provided pursuant to this chapter that is based upon the income level of the individual and the cost of the service provided. No individual whose documented family income is at or below 100 percent of the federal poverty level shall be subject to copayment. The copayment fee shall not be used to deny access to family planning services. State reimbursement to the provider shall be offset by that amount of the copayment collected from the eligible individual. The department shall notify providers on an annual basis of the copayment fee schedule.

24005. (a) Only licensed medical personnel with family planning skills, knowledge, and competency may provide the full range of family planning medical services covered in this program.

(b) Medi-Cal enrolled providers, as determined by the department, shall be eligible to provide family planning services under the program. Those providers electing to participate in the program shall provide the full scope of family planning education, counseling, and medical services specified for the program, either directly or by referral, consistent with standards of care issued by the department. The department shall require providers to enter into enrollment agreements with the department to ensure compliance with standards. Providers who do not provide services consistent with the standards of care may be disenrolled as a provider from the program.

(c) Enrolled providers shall attend specific orientation approved by the department in comprehensive family planning services. Enrolled providers who insert IUDs or contraceptive implants shall have received prior clinical training specific to these procedures.

24007. (a) The department shall determine the scope of benefits for the program, which shall include, but is not limited to, the following:

(1) Family planning related services and male and female sterilization. Family planning services for men and women include emergency and complication services directly related to the contraceptive method and followup, consultation and referral services, as indicated, which may require treatment authorization requests.

(2) All United States Department of Health and Human Services, Federal Drug Administration-approved birth control methods, devices, and supplies that are in keeping with current standards of practice and from which the individual may choose.

(3) Culturally and linguistically appropriate health education and counseling services, including informed consent; psychosocial and medical aspects of contraception, sexuality, fertility, pregnancy, and parenthood; infertility; reproductive health care;

preconceptual and nutrition counseling; prevention and treatment of sexually transmitted infection; use of contraceptive methods, devices, and supplies; possible contraceptive consequences and followup; interpersonal communication and negotiation of relationships to assist individuals and couples in effective contraceptive method use and planning families.

(4) A comprehensive health history, updated at next periodic visit (between 11 and 24 months after initial examination) that includes a complete obstetrical history, gynecological history, contraceptive history, personal medical history, health risk factors, and family health history, including genetic or hereditary conditions.

(5) A complete physical examination on initial and subsequent periodic visits.

(b) Benefits under this program shall be effective in 30 days after notice to providers, but not sooner than January 1, 1997.

24009. Family planning services are confidential. All information about personal facts and circumstances obtained by the provider shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the individual's written consent, except as required by law or as may be necessary to provide emergency services to the individual or as required by the department to administer this program. Information may be disclosed in summary, statistical, or other form that does not identify particular individuals.

24011. (a) Providers shall submit claims for reimbursement for services provided on or after January 1, 1997, or receipt of notice from the department, whichever is later, and covered by this program, to the fiscal intermediary of the department for payment. Charges and individual information shall be submitted on the form or in the format specified by the department for the state-only family planning program, and providers shall be reimbursed at the rates established for those services by the department.

(b) The department shall use existing contractual claims processing services in order to promote efficiency and to maximize use of funds.

(c) Claims for state-only family planning services provided through prescription, including laboratory and pharmaceutical, shall be reimbursed in a manner determined by the department. Eligible individuals shall not be charged for any state-only family planning laboratory or pharmaceutical services.

(d) Claims for method-related complications requiring approved treatment authorization requests shall be reimbursed regardless of category of medical service.

24013. (a) Notwithstanding any other provision of law, the department may adopt any procedures as are necessary for the review of a grievance or complaint concerning the processing of claims or payment of moneys alleged by a provider of services to be payable by reason of any of the provisions of this division.

(b) Any applicant for, or recipient of, services under the state-only family planning program shall have a right to a hearing conducted by the department regarding the person's eligibility or receipt of services. A proposed decision from the administrative law judge shall be submitted to the State Director of Health Services for adoption, modification, or rehearing. The decision of the director shall be final. A person shall not have a right to contest changes made to the eligibility standards or benefits of the state-only family planning program.

24015. The department may adopt emergency regulations as necessary to implement and administer this chapter in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The initial adoption of any emergency regulations following January 1, 1997, shall be deemed to be an emergency and necessary for immediate preservation of the public peace, health and safety, or general welfare. Emergency regulations adopted pursuant to this act shall remain in effect no more than 180 days.

24017. The program shall be exempt from the requirements of Chapter 7 (commencing with Section 11700) of Part 1 of Division 3 of Title 2 of the Government Code and Chapter 3 (commencing with Section 12100) of Division 2 of Part 2 of the Public Contract Code as those requirements apply to the use of contractual claims processing services by the department.

24021. The department shall conduct an evaluation of the effectiveness and efficiency of the program, including expanded access and reduction of unintended pregnancies, and shall report to the Legislature by no later than January 1, 2000. The department may use local assistance funds allocated to the State-Only Family Planning Program for the evaluation of the program.

24023. It is the intent of the Legislature that the State Department of Health Services shall, effective March 1, 1997, conduct no other general statewide program for the provision of comprehensive clinical family planning services as referenced in Chapter 8.5 (commencing with Section 14500) of Part 3 of Division 9, while the State-Only Family Planning Program authorized by this division is in effect. For the purpose of avoiding a disruption of services, to the extent the implementation of the State-Only Family Planning Program does not occur on or before March 1, 1997, the Director of Health Services may extend the general statewide program for the provision of comprehensive clinical family planning services as referenced in Chapter 8.5 (commencing with Section 14500) of Part 3 of Division 9. This extension shall be made only upon notification to the Chairperson of the Joint Legislative Budget Committee and the chairperson of the committee in each house that considers appropriations and under no condition shall extend beyond 120 days.

24027. This division shall remain operative only until July 1, 2000, and, as of January 1, 2001, is repealed, unless a later enacted statute, which becomes effective on or before January 1, 2001, deletes or extends that date.

SEC. 53. Section 24 of Chapter 305 of the Statutes of 1995 is amended to read:

Sec. 24. Notwithstanding any other provision of law, the emergency regulations developed pursuant to Section 14680 of the Welfare and Institutions Code to implement Part 2.5 (commencing with Section 5775) of Division 5 of the Welfare and Institutions Code shall remain in effect until July 1, ~~1996~~ *1997*, or until the regulations are made permanent, whichever occurs first, and shall not be subject to the repeal provisions of Section 11346.1 of the Government Code until that time.

SEC. 54. (a) No later than February 15, 1997, the State Department of Alcohol and Drug Programs shall provide a report to the chairs of the fiscal committees and policy committees of the Legislature on each of the audits, studies, and surveys required by this section.

(b) The State Department of Alcohol and Drug Programs shall contract for an independent audit of the department's financial procedures for allocation of funds and reimbursement of costs for treatment services, including the department's procedures and timelines for allocation of funds by counties. The department shall contract with the Bureau of State Audits for this function.

(c) The State Department of Alcohol and Drug Programs, in consultation with the State Department of Health Services, shall contract with an actuarial firm for an independent study of drug and alcohol treatment rates to determine the actual costs of providing drug and alcohol treatment and ancillary services in programs funded through the department. The study shall include and compare all costs of treatment services including the use of funds from other governmental and nongovernmental sources. The purpose of this study shall be to provide the department with a factually correct, statistically valid data base sample to set statewide rates for each service.

(d) The State Department of Alcohol and Drug Programs in consultation with counties and drug and alcohol treatment providers shall develop a survey to be issued to all counties for distribution to all providers. The survey of the alcohol and drug treatment services funded

through the State Department of Alcohol and Drug Programs shall include at least all of the following:

(1) A determination of the required length of time to complete the program, if any.

(2) The number of clients who entered the program and the number who completed the program, if applicable.

(3) How many clients were terminated from the program and the causes for those terminations.

(4) The number of times each client was previously in treatment.

(5) How many and what type of followup services are provided to clients upon completion of the program.

(6) What ancillary services are provided during and following treatment.

(7) The number of clients receiving each service.

(8) The description of services provided.

(9) Each county's procedure timelines for allocation of funds and reimbursement of costs.

(10) What services include family members of clients.

(e) The data from this survey shall be collected and analyzed by an actuarial firm and validated by the Bureau of State Audits.

SEC. 55. The State Department of Health Services shall report to the Legislature, by March 1, 1997, on the following data with respect to the child health and disability prevention program provided for pursuant to Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code:

(a) The number of children, by age, enrolled in each health plan contracting with the state.

(b) The number of children, by age, who received a comprehensive examination under the child health and disability prevention program in each health plan contracting with the state that is capitated for child health and disability prevention program services.

(c) It is the intent of the Legislature that the State Department of Health Services' Division of Medical Care Services and Division of Primary Care and Family Health cooperate in the development of shared information

capability. To the extent this capability exists, the department shall also include in the report required by this section the number of children, by age, in each health plan contracting with the state and that is capitated for child health and disability prevention services, referred for followup diagnosis or treatment from a child health and disability examination. To the extent this capability does not exist, the department shall also identify in this report the barriers to the development of shared information and reporting capability, and the cost to develop this capability.

SEC. 56. The State Department of Health Services may adopt emergency regulations to implement this act in accordance with the Administrative Procedure Act, Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The initial adoption of emergency regulations and one readoption of the initial regulations shall be deemed to be an emergency and considered by the Office of Administrative Law as necessary for the immediate preservation of the public peace, health and safety, or general welfare. Initial emergency regulations and the first readoption of those regulations shall be exempt from review by the Office of Administrative Law. The emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations and shall remain in effect as emergency regulations for no more than 180 days.

SEC. 57. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Notwithstanding Section 17580 of the Government Code, unless otherwise specified, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution.

SEC. 58. If any provision of this act or the application thereof to any person or circumstances is held invalid, that invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

SEC. 59. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to timely provide for the administration of this act for the entire 1996–97 fiscal year, it is necessary that this act take effect immediately.

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